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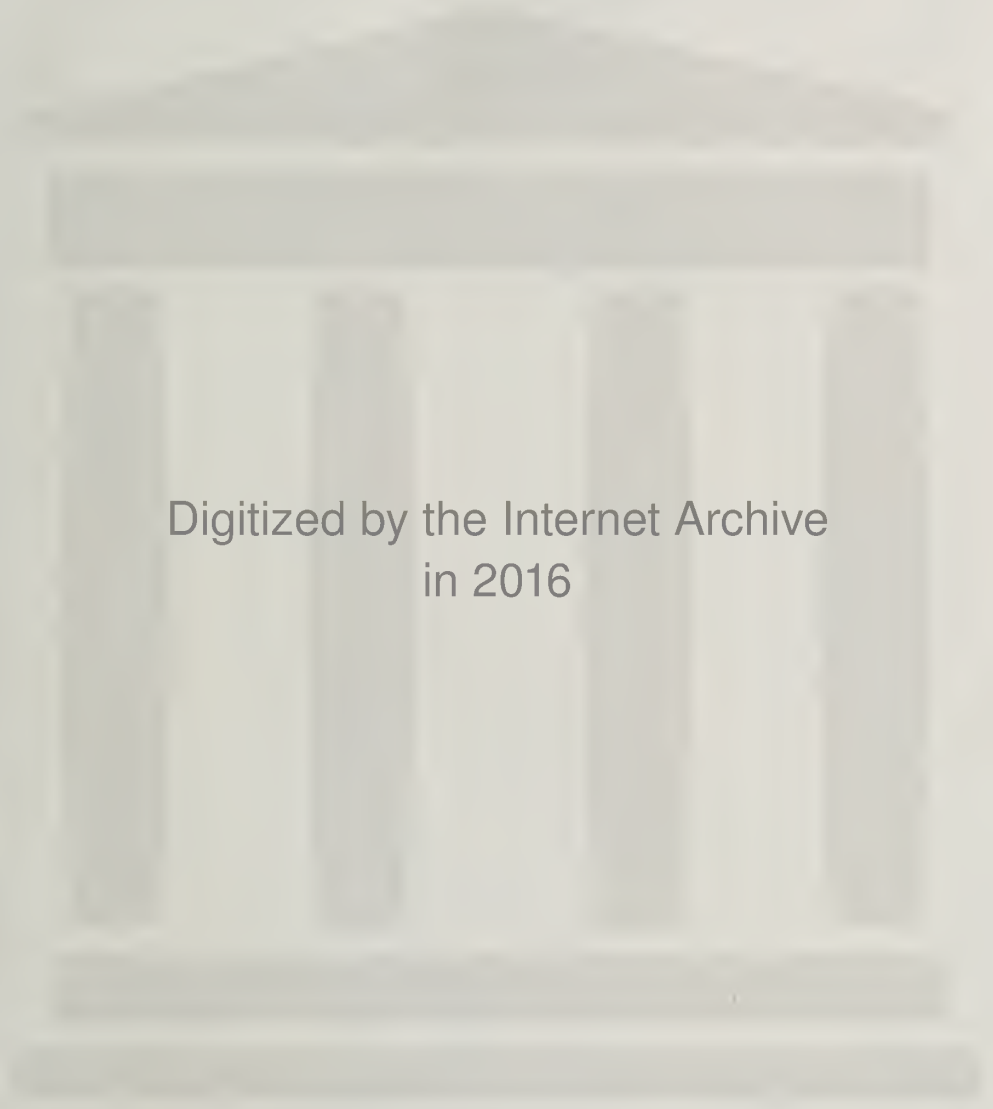


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The Journal

THE OKLAHOMA STATE MEDICAL ASSOCIATION

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EDITORIALS

OUR MEDICAL SCHOOL

All readers of the Journal are interested in medical education. Many have a material stake in our own school and its allied organizations. But few realize what it means to maintain a modern medical school, with all its administrative and scientific ramifications.

Daily those responsible for its operation must face the eternal issues, and attempt to solve the ever recurring enigmatical problems. This applies from top to bottom; to administrative officials and faculty alike. With scientific progress, increasing knowledge and the resulting pressures, it applies more forcibly than ever before.

Today aside from all this, there is a fresh wind blowing through the corridors of American medical schools. It is the Student American Medical Association in action. Will it prove to be the voice of Isaiah crying against incompetence and injustice or the destructive blast of an unreasoning Nero ready to burn the eternal citadel. There is nothing new about this except that the pent up currents are being released by the youth of an alert, outspoken generation.

If Robert Burns were here today, someone would exclaim, "Louse, louse!" And spare him the plea, "O wad some pow'r the giftie gie us to see oursels as ithers see us."

Let us hope that this obvious stirring of the immemorial cross currents between faculty and student body may prove to be a conservative, cleansing, renovating force and not a destructive storm burying both students and faculty in the wreckage.

The experience of those who have both studied and practiced medicine and particularly those who have held teaching positions in medical schools may help to temper the wind. They know the faculty lambs shorn and unshorn and their susceptibility to chilling blasts. Likewise, they know that throughout the history medical schools have had both good and bad teachers for the instruction of both good and bad medical students and that both are stimulating and provocative and conducive to good scholarship. The good inspire and lead; the bad provoke and speed intellectual activity. Also they know it is possible for the exceptional student to forge far ahead of some of his professors and fortunately they know that deBury was right when he said, "Books are the masters that instruct us without words of anger, without payment of money or clothing." Books do not laugh at ignorance and error, neither do they chide. They are free and liberal and reward all who seek. Those who have been seasoned by experience also know that perfection is Divine and that Divinity in this world throughout the ages has been attributed to only one Person. Apropos what has been said it is interesting to note that Robert Louis Stevenson, after attending some lectures on medicine said, "Whither goeth all uncouth medical students and whence cometh all worthy doctors."

Fortunately, the buoyant, impulsive winds of this body of worthy students hard on the trail of medical knowledge first blow upon experienced medical advisors who serve in response to the student body's own initiative. All this is hopeful, and if wisely controlled and carefully integrated, potential of great good. Always our hats are off to the enterprising youth in our midst who, under the inevitable one world concept must chart the uncertain future. First our prayers are for those who are chosen as their advisors, secondly we pray for the guidance of the courageous, forward looking student body of this generation and finally, for all concerned after eliminating every vestige of "ill weaved ambition." Let us pray with Plato, "O Jupitor, give us good things whether we pray for them or not, but withhold all evil things even though we pray for them."

PERSPECUITY

In spite of Oscar Ewing's six tons of preelection press releases, Mr. Truman has had his last whistle stop and the President-Elect is retiring the so-called Federal Security Agent with his "Hobby."

Thank God, Eisenhower and the people for this final stroke of perspicuous significance.

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THE PATIENT-PHYSICIAN RELATIONSHIP SHOULD BE REVITALIZED OR DISCARDED AS A SLOGAN

Looking at the past, considering the present and contemplating the future may become an interesting but disturbing pursuit. When considered by the thoughtful physician such retrospective and prospective speculations give rise to many serious questions.

Since our sovereignty was secured by the American Revolution, our borders have extended with a pattern conforming to what might be considered a beneficent manifest destiny. This cannot be said of our political philosophies, our moral and spiritual progress or our socio-economic conditions.

In the millieu, medicine stands efficient with untold past achievements, fabulous present skills and potentialities that stagger the imagination, yet professional rating by the laity stands on shifting sand. Many people who through the good offices of the medical profession have reached maturity and profited by lengthened longevity are unhappy with modern medical care and are audibly critical of their greatest benefactors. Repeatedly in these columns this sad state of affairs has been revealed with a frank discussion of cause and effect.

Obviously, it is impossible accurately to appraise all the factors entering the cauldron in which our troubles are cooking and to estimate their respective contributions to the confusing fog of unrest issuing from the ominous pot. But be it ever so smug, the medical profession must bear its part of the blame. First of all the cauldron boils with the sins of omission. In the last analysis the patient-physician relationship is the most important factor in the practice of medicine. This relationship has suffered from neglect. Whether this be due to indifference, ignorance, pressure of practice or lack of understanding it is serious. Regardless of the cause, it has resulted in a rift that is widening into a gulf. The efficient, yet cold impersonal hand of science can never take the place of the sympathetic arm of the art. The physician who would heal the tired body must encompass and comfort the troubled soul. This is no secret trick reserved for the psychiatrist but the plain duty of every practicing physician. If medicine is to be saved, the patient-physician relationship must be improved and preserved. If medical education is at fault, the remedy should be found; if careless or unprofessional methods of practice are to blame, they must cease, otherwise medicine will fail in its mission and practice will become a drab, uninteresting pursuit; a function fit only for a welfare state under the sickening command of police powers. Let not cold, calculating science wholly replace the warmth of a sympathetic personality. Though a robot may become a competent calculator it can never be a good companion.

Though we have excelled in science and made rapid, mechanistic progress, people are still endowed with common sense and still attuned to feeling. Let the members of the medical profession call this emotion if they will, and spurn it if they choose, but in so doing they are toying with their future and sealing their fate.

Doubling life expectancy does not endear the patient to his physician. It is too impersonal. The patient's affection is won through frank and friendly attention, relief of pain, ease of mind, surcease of soul. These ends are achieved only through mutual understanding which may require time and effort.

Unfortunately, the disappointed patient seldom complains directly. The dissatisfaction invades the home, leaks out at social gatherings, filters into the County and State Medical Association offices and too often it travels all the way to Washington to make capital for the bureaucrats.

This is not a job for the new Administration. It's time to call a meeting for a complete housecleaning. After a free and frank discussion each member of the profession must survey his past patient-relationships, dust off his conscience, refurbish his service ideals, scrutinize his material ambitions, grease and regear his medico-socio-economic differential and get the old relationship going.

In support of the above, the following quotation from Thomas Miner (1823)[1]:

"To carry the healing art to the highest perfection, of which it is susceptible, more skill, more learning, more industry, and indeed, more integrity, are requisite in the members of the medical faculty, than in those of any other profession.

". . . The mercenary practitioner, who is destitute of zeal in the cause of humanity, who has no love for his profession, who feels no ardour in the pursuit of studies and observations, which leads to its improvement, but pursues an indolent routeine, and for the emolument only, makes a trade of

his practice, must have first extinguished every principle of humanity, of honour, and of moral responsibility."

1. Essays on Fevers and Other Medical Subjects. Thomas Miner, M.D. and William Tully, M.D., Middletown, Conn. Printed and published by E. and H. Clark, 1823. Page x, Preface.

THE WORLD MEDICAL ASSOCIATION

In October the World Medical Association met in Athens, Greece, where Hippocratic medicine helped to initiate the age of enlightenment and where Plato compared medicine and politics and considered them parallel in human weal, medicine for the good of the body and politics good for the soul.

Since politics is no longer so good for the soul and seeks to gobble up all professional freedoms, liberty loving physicians throughout the world must be on guard.

While we would like to believe that medicine in the United States is self-sufficient, we must admit that perhaps more than any other nation we have helped to bring about the one-world concept. Now that we live in the center of this one-world, we must shoulder our share of professional responsibility.

It is this sense of responsibility in the sight of our philosophy of medicine as it relates to political control that has caused the United States Committee (representing our membership) to continue active participation and financial support. Since we must remain world conscious, we must do what we can to preserve universal professional freedom. Already the World Medical Association has served in this capacity in connection with the World Health Organization, UNESCO, and the International Labor Organization.

The meeting at Athens, representing approximately ¾'s million physicians represented by 43 countries was an intriguing and inspiring spectacle. While the experience gave rise to a worthy sense of pride, it was mingled with both hope and fear. Common agreement with reference to professional freedom and the dangers inherent in the universal craze for so-called social security was most encouraging. The World Medical Editors meeting in conjunction with the World Medical Association, should contribute a stabilizing influence and supply sound editorial publicity.

The following from an editorial in the *British Medical Journal*[1] will give our readers a beter understanding of the W.M.A., and the professional and financial support tendered by the A.M.A.:

"A statement by the World Medical Association appended to its ninth principle has some relevance here. 'The Cultural and ethical standards of a civilized society depend for their maintenance and promotion principally upon the integrity and example of the learned professions . . . There is a grave danger that social security schemes, however idealistically conceived, will progressively diminish the cohesive moral and cultural force emanating from the corporate life of the learned professions. The fundamental fallacy of the planners of social security schemes is the ignoring of this force, coupled with a tendency to regard practising doctors merely as technicians employing certain technical skills.' "

1. Professions in Peril, British Medical Journal. No 4792. November 8, 1952, page 1033.

HUMILIATING

Times' story of crooked doctors in California's Physician's Service is truly embarrassing. Every time a single member of the medical profession is found guilty of wrongdoing, the profession as a whole suffers untold damage.

That only a few of the 11,500 participating physicians were found guilty of abusing or overusing the service does not remove the blot from our treasured escutcheon. Neither are we absolved by suggesting that this is only a sign of the time; the natural result of the existing socio-economic confusion; or the impersonal relationship with blunted sensibilities and atropy of conscience.

With Dante's Purgatorial allegory in mind, let us resist the sin that shames us and admit the light that eradicates the evil disposition ever ready to tempt us.

We can only pray for power to live with a clear conscience and to die with clean hands.

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Scientific Articles

REGIONAL ENTERITIS ISOLATED TO THE JEJUNUM: A REPORT OF TWO CASES

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OKLAHOMA CITY, OKLAHOMA

At the time of Gregg and Weisser's[1] recent review of the literature of regional enteritis, 85 cases of isolated jejunitis had been reported.

We feel it is worthwhile to report two additional cases of jejunitis proven at operation.

Case I—J.H., 51-N-M: A 51-year-old Negro male with no significant past history except for adequately treated syphilis.

He complained of mild episodes of epigastric distress for seven or eight years, occurring mainly in the spring and fall, which were sometimes relieved by sodium bicarbonate. Highly seasoned foods, cabbage and onions had aggravated this pain in the past. Approximately two years ago, he began having frequent episodes of left upper quadrant pain at times associated with vomiting. Frequently the vomitus contained food ingested the previous day. On May 20, 1950, he was seen in the out-patient department of St. Anthony Hospital, complaining of pain in the left upper quadrant.

A flat plate of the abdomen revealed dilated bowel containing gas in the left upper quadrant believed to be jejunum. A gastrointenstinal series on May 22, 1950, revealed a narrowed area about 10 cms. distal to the ligament of Treitz in the jejunum. Admission to the Hospital was advised but the patient refused.

The patient was again seen on March 17, 1951, complaining of the same symptoms, however by this time he was having so much discomfort that he was afraid to eat. He had lost approximately 15 pounds during the preceding two months.

Physical examination at this time revealed a very thin man in no acute distress. B.P. was 110/74. Heart and lungs seemed normal. The abdomen was flat and there were no visible peristaltic waves. There was slight tenderness over the whole abdomen with the exception of the right upper quadrant, but no rebound tenderness. Peristalsis was normal. There were palpable masses. Rectal examination was negative.

X-rays on March 19, 1951, revealed the same narrowing in the jejunum without appreciable change.

Surgery was scheduled for March 22, 1951, however because a Miller-Abbott tube gave discomfort, he refused surgery and left the hospital without permission.

The patient returned to the hospital on April 19, 1951, because he was able to retain food for only a few hours. The physical findings had not changed since his previous admission.

On April 21, 1951, under general anesthetic, a left upper paramedian incision was made into the peritoneal cavity. There were no abnormalities of the stomach, duodenum, biliary system, pancreas or large intestine. The small intestine was examined from the ligament of Treitz to the ileocecal valve, and appeared normal except in the upper jejunum. A firm encircling mass was present in the jejunum approximately 20 centimeters distal to the ligament of Treitz. The mass was about three centimeters in length. The proximal jejunum was about one and one-half times dilated. The adjacent mesentery was thickened. Approximately 18 centimeters of jejunum was resected with a wedge of mesentery and the bowel joined end to end. The patient had an uneventful postoperative course.

Pathological examination revealed a constricting lesion with only a 2 mm. opening at the smallest diameter of the lumen. The lesion was ulcerated with a ragged margin. Microscopic diagnosis: "Diffuse inflammation and ulceration. The usual fibrous reaction of peptic ulcer is not present. The lesion is altogether more consistent with regional enteritis".

Case II — H.M., 48-W-F: A 48-year-old white female had a negative past history ex-



CASE I

Narrowing of a segment of jejunum distal to ligament of Treitz, the site of disease. Some dilatation of jejunum proximal to lesion. Very little change in appearance of lesion in nine months.

CASE II

Normal stomach and duodenum. Dilatation of jejunum proximal to an irregular segment of narrowed bowel, the site of disease.

cept for episodes of pain in the upper abdomen of six years duration. The gallbladder did not visualize with dye six years ago.

On January 7, 1950, this patient began to have severe cramping abdominal pains more marked in the left upper quadrant and frequent vomiting. On the following day, she noticed her abdomen was larger and one tarry stool was passed. Narcotics gave only slight relief. She was admitted to St. Anthony Hospital, January 10, 1950.

A flat plate of the abdomen two days after gastric suction revealed a dilated portion of proximal jejunum which contained gas. Subsequent barium roentgen studies revealed a narrow segment of jejunum approximately 1 centimeter in length with dilated bowel proximal to the narrowing, this dilated portion retained barium for eight hours. The gallbladder did not function after a double dose of dye. She became asymptomatic after six days and although she was advised to have surgery, refused and left the hospital.

The patient had only slight discomfort as long as she limited her diet to baby foods.

Repeat x-rays revealed the same picture as before and she re-enetered St. Anthony Hospital, March 4, 1950, for surgery.

On March 8, 1950, under general anesthesia an upper transverse incision was made into the peritoneal cavity. An obstructive lesion in the jejunum approximately 45 centimeters distal to the ligament of Treitz was found with marked dilatation of the proximal jejunum. There was some thickening in the adjacent mesentery. Remaining small bowel was negative. Approximately 20 centimeters of jejunum were resected along with a wedge of mesentery. A side-to-side anastomosis was made with remaining jejunum. Cholecystostomy and lithotomy was done. She had an uneventful convalescence and was discharged on March 22, 1950. Microscopic diagnosis: "Benign probably ulcerative jejunitis".

DISCUSSION

It is of interest to note that the duration of symptoms in each of these patients was six years. In Case II, chronic gallbladder disease with calculi may have been the cause of some recurring epigastric distress. In Case I, there were no other complications and very little change could be noted in the roentgen studies over a nine month period. Other investigators have noted the chronicity of the disease and how often the symptoms are attributed to other abdominal pathology, frequently because of the periodicity of the pain and relation to eating, gastric and duodenal ulcer are often diagnosed. It would seem to be a valuable routine for the roentgenologist to follow the barium meal into the jejunum well past the ligament of Treitz in all cases where epigastric symptoms cannot be explained on the findings in the stomach or duodenum.

CONCLUSION

Two examples of localized non-specific jejunitis are added to the literature bringing the total of reported cases to less than a hundred. We believe the diagnosis of jejunitis should be considered in all cases of unexplained epigastric distress.

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THE INCREASING INCIDENCE OF CORONARY ARTERIOSCLEROSIS IN DIABETES MELLITUS

PRELIMINARY MANUSCRIPT

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The chief cause of death in diabetics with onset of the disease in adult life is now coronary arteriosclerosis.

Because of the many recent advances in the therapy of diabetes, the problems of this disease are continually changing. That degenerative vascular lesions are now responsible for the vast majority of deaths in diabetics with onset of disease in adult life will be shown by reporting recent autopsy statistics. These statistics will illustrate the remarkable decline in the incidence of coma, infection, and gangrene as causes of death and will show an incidence of myocardial infarction higher than has been previously reported.

Wilson and Joslin have shown that the majority (51.9 per cent) of childhood diabetics who die between the ages of 25 and 40 years die of degenerative kidney disease.[1] The observations of Root, Sinden, and Zanca[2] indicated that among young patients whose diabetes began between the ages of 15 and 30 years, the degree to which diabetes was controlled by careful observation of diet prescription, and by adjustment of insulin dosage in the attempt to maintain a sugar-free urine, was correlated with the postponement and prevention of vascular changes. This point was clearly substantiated by the data of Wilson, Root, and Marble upon 247 patients with diabetes beginning between ages of one year and 29 years.[3]

Thus the clinical course of diabetes varies according to the age of onset. The majority of our younger diabetics succumb to degenerative renal disease, while the majority of our patients with onset of diabetes in adult life (51 per cent) die as a result of coronary arteriosclerosis. Whether the postponement of coronary arteriosclerosis in this older group may be accomplished by improved control of diabetes is a most important problem.

MATERIALS AND METHODS

The causes of death in 100 cases of adult diabetes autopsied at the New England Deaconess Hospital are listed in Table 1. The age of onset of diabetes mellitus ranged from 22 years to 74 years and the duration of diabetes from 2.2 to 31 years. The deaths occurred during the period January, 1948, to May, 1951, and are consecutive except that three cases were omitted where, even after partial or complete autopsy, reasonable doubt was present as to the exact cause of death. Also excluded was one case of hemochromatosis. The oldest patient at time of death was 84 years and the youngest 32 years.

An attempt was made in each case to attribute death to a single pathologic process. Therefore, only the disease which contributed most heavily to the patient's demise is listed. For example, a case of carcinomatosis with subsequent heart failure and agonal pneumonia was listed only as death due to the neoplastic process. In a few cases, however, it was not possible to select a single entity, and in these cases both diseases are listed. Figure 1 is a diagrammatic representation of the principal causes of death in this group of adult diabetics. In computing the total percentage for each pathologic entity one per cent was added when that process was the single most important cause of death, and one-half of one per cent was added when that process shared equal responsibility with another entity.

Incidental pathologic findings were not tabulated even when those entities contributed secondarily to the patient's death.

We are aware that the study of necropsy material in one hospital does not reflect the complete picture of diabetic mortality, but it is one way in which progress in diabetic therapy can be measured and future goals clarified.

CAUSES OF DEATH

DEGENERATIVE VASCULAR DISEASES: Table 1 shows that 64.0 per cent of the deaths were due to degenerative vascular disease. This group includes coronary arteriosclerosis (51 per cent), cerebral arterial disease (8.5 per

cent), and pulmonary embolism (two per cent). The incidence of acute myocardial infarction as a cause of death (41 cases) is particularly striking and will be discussed specifically below.

During the period 1898 to 1914 (Naunyn Era only 17.5 per cent of deaths in diabetics were due to diseases of the heart, kidneys and vascular system.[4a] This figure had gradually increased until it reached 61 per cent in a study of 100 autopsied cases (patients with onset of diabetes in adult life) during the period 1940-1945.[5] Sclerotic lesions accounted for 61.6 per cent of diabetic deaths in a series recently reported by Blumberg and Zisserman.[6] The present figure (64.0 per cent) for deaths due to degenerative vascular disease does not represent an appreciable increase over the incidence in our figures for the period 1940-1945. The reason for this lack of appreciable increase is explained by the fact that gangrene of an extremity which was formerly responsible for 10 per cent of deaths of adult diabetics (1940-1945) caused no deaths in the group tabulated in Table 1. Thus the increase in mortality due to coronary disease was largely balanced by a decline in the death rate due to gangrene. The decline in mortality, due to gangrene is due mainly to the availability of the antibiotics, which have enabled earlier, less extensive, and safer surgery.

CORONARY ARTERIOSCLEROSIS: Coronary artery disease resulted in death of 51 per cent of patients in the present series. In addition to the patients who died as a direct result of coronary arteriosclerosis there were an appreciable number in whom advanced coronary disease was demonstrated at autopsy. In several cases (not included in the 51 per cent) manifestations of coronary arteriosclerosis contributed secondarily to death. In 110 diabetic autopsies at the Deaconess Hospital, during the period 1940-1945, coronary arteriosclerosis of varying degree was demonstrated in 108 cases.[5] By using the Schlessinger injection technique Stearns, Schlessinger and Rudy found that 74 per cent of a consecutive diabetic series had functionally significant coronary arteriosclerosis. This was opposed to 37 per cent of a control series.[7]

The frequency of angina pectoris in the diabetic markedly exceed the frequency of this syndrome in the general population. [4b 7] In 210 diabetic cases angina pectoris was preceded by diabetes in 188 instances. In 13 cases angina pectoris and diabetes developed spontaneously, and in only nine cases did angina precede diabetes.[8] This increased incidence of angina pectoris is further evidence of the effect of diabetes on the pathogenesis of coronary arteriosclerosis.

MYOCARDIAL INFARCTION. The extremely high incidence of myocardial infarction as a cause of death, was indicated by 39 cases in which death was due primarily to infarction, two cases in which myocardial infarction shared equally the responsibility for death with another factor, and one case in which acute myocardial infarction was only an agonal event. Thus acute myocardial infarc-

CAUSE OF DEATH	Primary cause of death	Responsibility for death shared equally with another entity
Myocardial infarction	39	2
Congestive heart failure due primarily to coronary arteriosclerosis	9	4
Total due to coronary arteriosclerosis	48	6
Cerebro-vascular episodes*	8	1
Pulmonary embolus	2	0
Renal vascular disease	1	3
Total due to degenerative vascular disease	59	10
Renal infection	7	3
Pneumonia	5	0
Other infections	1	1
Total deaths due to infection	13	4
Cancer	18	0
Coma	0	1
Hypoglycemia	0	0
Gangrene	0	0
All other causes	2	1
TOTALS	92	+ 16 × ½ = 100

TABLE 1. *Causes of death in 100 patients with onset of diabetes in adult life autopsied at the New England Deaconess Hospital 1948-1951.*

**One of these patients had essential hypertension.*

tion was found in 42 of the 100 autopsied cases. Of these 42 cases of acute myocardial infarction eight cases showed at autopsy evidence of one or more areas of old infarction. In addition to these cases, old myocardial infarction was found in seven other instances. About one-half of these patients (42 per cent) had experienced one or more episodes of myocardial infarction. Table 2 shows how the incidence of acute coronary disease in diabetics has steadily increased.

The 42 cases of acute myocardial infarction were further analyzed. The oldest case was 84 and the youngest 46. The average age at death in this group was 67.5 years. The average age at onset of diabetes was 52.1 years, thus the average duration of diabetes was 15.4 years. Since the average life expectancy at age 52 was approximately 20 years, [12] then these cases of myocardial infarction survived 77 per cent of their collective life expectancy.

Rupture of the myocardium occurred in five cases (12.1 per cent) This is considerably higher than the incidence (3.2 per cent) of rupture in a largely nondiabetic series of fatal infarction reported by McCain et al.[13] It also exceeds the incidence reported by McDonald and Bentley (eight per cent) in a largely nondiabetic series.[14] It may be that the increased incidence of cardiac rupture was due to the excessive amount of coronary artery disease present in these diabetics. The series, however, is rather small for conclusive proof of an increased incidence of rupture.

The average age at death (67.5 years) of our fatal cases of cardiac infarction exceeded by six years the average age in a series of largely nondiabetic patients reported by McCain, Klein, and Gilson.[13] The average age at onset of infarction in a series of largely nondiabetic cases reported by Mintz and Katz was 60.4 years.[15] This group is not entirely comparable with ours, since their series is a consecutive one (not necessarily fatal cases). However, it is probably fair to state that the age at death (67.5 years) in our series exceeds the average age at death of nondiabetic cases of myocardial infarction. The chief factor responsible for the late onset of infarction was probably the fact that the average age at onset of diabetes was 52.1 years. Thus, cardiac infarction did not occur until the duration of diabetes (average 15.4 years) had had its effect.

It has been shown previously that the onset of myocardial infarction occurs a few years later in women than in men.[15,16] The predominance of women in this series (64 per cent) may partially explain the late onset of infarction in the group. This unusually high incidence of females in a series of myocardial infarction cases is due partially to the excess of females over males among adult diabetics, but it is also a reflection of the fact that diabetes is a more potent predisposing agent in the pathogenesis of coronary arteriosclerosis than are sex factors. Robinson concluded that coronary thrombosis was 14 times more likely in a diabetic woman than in a nondiabetic woman.[17]

Robbins and Tucker[18] found coronary occlusion two and one-half times as frequent in diabetics as in nondiabetics. Studies by Root, Bland, Gordon, and White showed the frequency of coronary occlusion to be 5.3 times greater in diabetics.[19] Master reported in 1947 that approximately 8.5 per cent of the general population died of coronary disease.[26] This compares with the figure of 51 per cent in our series of adult diabetics in a ratio of 1.6. Since our patients were all older people (average age 67.5) the above comparison is not entirely a fair one, but gives a general idea of the marked influence of diabetes on the pathogenesis of coronary artery disease. Stearns and his colleagues compared the incidence of acute coronary disease (34 per cent) in their diabetic series to a control series in which the incidence was 14 per cent.[7]

The very high incidence of myocardial infarction in diabetics is, of course, mainly due to an acceleration of the rate of coronary sclerosis, but the increased incidence of obesity and hypertension in diabetics also favors the development of coronary occlusion. Bailey in reviewing 500 diabetic autopsies found significant coronary arteriosclerosis in 39.1 per cent of the overweight patients, and in only 27.4 per cent of the patients of normal weight.[21] The high incidence of hypertension in diabetics has been repeatedly shown[8,22,23,24,25], and is largely due to the renal lesions which will be discussed below.

In the years 1940 to 1945 there were 96 cases of coronary occlusion at the New England Deaconess Hospital.[4c] Forty-two of these cases died in the hospital, and 10 other cases died soon after discharge. This would seem to attach a relatively grave prognosis to this complication of diabetes. Other authors [26,27,28] have found that diabetes adds

Year reported	Per cent of deaths due to acute coronary disease	Reported by	Nature of series
1930	10 per cent (''cardiac infarction'')	Blotner	consecutive cases
1936	21.7 per cent (''acute coronary thrombosis'')	Root and Sharkey	consecutive cases
1942	30 per cent (''cardiac infarction'')	Lisa, et al.	cases over 40 years of age
1947	34 per cent (''acute coronary disease'')	Stearns, et al.	average age at death 64.7 years
1952	40 per cent (''myocardial infarction'')	Root and West	average age at death 67.5 years

TABLE 2. *The rising incidence of fatal acute coronary disease in diabetes.*

to the gravity of the prognosis in myocardial infarction. On the other hand, in a large series recently reported by Smith et al,[16] the presence of diabetes was not associated with an increased mortality rate.

All cases of myocardial infarction should be screened for evidences of diabetes, because of the frequent association of the two diseases. Caution must be used, however, in interpreting the results of blood sugar testing which is carried out shortly following the infarction.[28,29] Ecerstrom demonstrated a mild transitory hyperglycemia in 111 of 162 nondiabetic cases of myocardial infarction.[28]

The treatment of myocardial infarction in the diabetic does not differ greatly from therapy in the nondiabetic case. Of course, hypoglycemia is to be meticulously avoided, but it is advisable to continue careful control of glycemia. In the present series there was no evidence to show that hypoglycemia had been a factor in the onset or fatal termination of any case of myocardial infarction. Since infarction is often associated with decreased carbohydrate tolerance, it is often necessary to increase the insulin dose above that ordinarily required. In an occasional case this increased insulin requirement will suggest or help confirm the diagnosis of infarction.

It is the opinion of Morrison[30] that administration of choline can appreciably delay the progression of coronary arteriosclerosis. We have not as a rule given our patients lipotrophic drugs. Certainly continued investigation of these drugs is merited in order to prove or disprove their efficacy in delaying coronary arteriosclerosis.

Since it has been shown that careful control of diabetes can prevent or delay the onset of degenerative vascular lesions in young patients,[2,3] it would seem reasonable to assume that careful control of diabetes would delay the development of coronary arteriosclerosis in older patients.[4d] Delay in starting insulin has resulted in an increased incidence of peripheral obliterative vascular disease in our patients. In a series of 500 diabetic autopsies Bailey reported an incidence of significant heart disease in 55.2 per cent of poorly controlled patients as opposed to an incidence of 30.2 per cent in well controlled patients.[21] These facts suggest that postponement of coronary sclerosis is possible through careful control of diabetes, but certainly more study should be given this matter.

CEREBRAL VASCULAR DISEASE. Cerebral disease was the chief cause of death in eight per cent of these cases. In one of the eight cases essential hypertension was present. There was an additional case in which a cerebral vascular episode shared the responsibility for death with another disease. Jordon and Watters[31] after studying 70 cases of cerebral vascular episode in diabetics concluded that cerebral vascular disease in the diabetic simulated the behavior of that disease in the nondiabetic. This experience was confirmed by the statistics of Root and Sharkey[25] and by the present study.

In view of the marked acceleration of sclerosis in the arteries of the heart, kidneys, and extremities produced by diabetes, the comparative infrequency of premature cerebral vascular disease is interesting. The peculiar tendency of diabetes to effect selectively certain groups of arteries has not been explained. The premature arteriosclerosis produced in animals by the feeding of cholesterol is similar to diabetic sclerosis in that certain groups of arteries are greatly affected, while others are spared. Under ordinary circumstances neither cholesterol feeding[32] nor diabetes seem to appreciably

accelerate the rate of cerebral arteriosclerosis, but both have a profound effect on the rate of coronary sclerosis. In a few of our juvenile diabetics of long duration the degree of cerebral vascular disease has exceeded the degree of vascular disease elsewhere. Thus, while premature cerebral arteriosclerosis does not necessarily occur in diabetics it is occasionally seen.

RENAL DISEASE. Kidney disease is now the most important cause of death in juvenile diabetes (51.9 per cent).[1] Although less important as a cause of death in adult cases, degenerative kidney lesions do present a major problem in adult diabetes. Well-marked renal lesions were demonstrated in 45 per cent of 100 adult diabetics autopsied at the New England Deaconess Hospital during the period 1940 to 1945.[5] In the present autopsy series 11 per cent of patients died as a result of renal disease. In 8.5 per cent acute and/or chronic infection played the major role, while in 2.5 per cent degenerative vascular lesions were responsible. The simultaneous occurrence of two or more types of renal pathology was commonly seen, especially in cases of long duration.

Although kidney lesions were the primary cause of death in only 11 per cent of this group, renal disease was an important (although secondary) factor in many of the other deaths. The secondary hypertension which is so often produced by renal pathology contributed appreciably to the high incidence of cardiovascular deaths.

Intercapillary glomerulosclerosis, although present in several cases, was the principal cause of death in only one instance. Since the Kimmelstiel-Wilson lesions occur so commonly in poorly controlled juvenile patients of long duration,[33,34] it has been our conclusion that the development of intercapillary glomeruloscleross is a function of (a) duration of diabetes, (b) severity of diabetes, and (c) lack of control of diabetes. Figures comparing the number of cases of intercapillary glomerulosclerosis in adult and juvenile diabetics are completely meaningless until one takes into consideration the fact that adult diabetes is many times more frequent than juvenile diabetes. After such a comparison one can easily see that although there are many cases of intercapillary glomerulosclerosis in adult diabetics, the relative incidence is much higher in childhood diabetes.

Bell[24] holds the opinion that Kimmelstiel-Wilson lesions represent a severe form of renal arteriosclerosis. Since our cases of intercapillary glomerulosclerosis have shown much associated renal vascular disease, we are inclined to share this view. One case, however, has been reported in which intercapillary glomerulosclerosis was unaccompanied by renal arteriosclerosis.[35]

In this series the mortality from renal infection was greater than the mortality resulting directly from renal vascular changes. Since renal infection is largely preventable, careful clinical attention to this problem is indicated. Because of the marked susceptibility of the diabetic urinary tract infection,[37] frequent examinations of the urinary sediment for evidence of infection are necessary, and aggressive therapy is advisable when the infection is found. Additional investigative procedures such as intravenous pyelograms, urine cultures, and specific antibiotic sensitivity tests are often necessary for proper evaluation. This problem has been considered so important that a special clinic has been created at this hospital for treatment and follow-up of these patients. Infection of the urinary tract with two or more organisms is common. Because of the necessity for repeated catheterization it is advisable to have these catheterizations carried out only by persons experienced in the procedure under the strictest of sterile circumstances.

If septicemia develops in a diabetic patient the initial focus should be considered to be in the kidney until proven otherwise.

SUMMARY

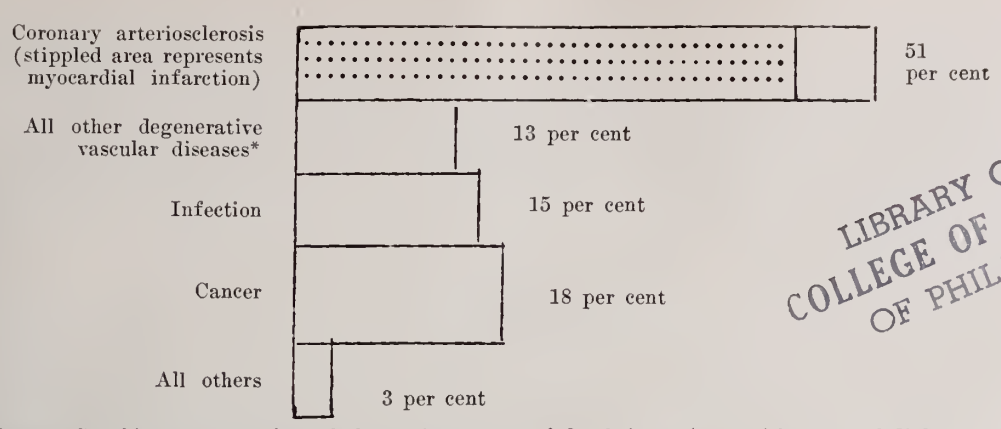
Coronary arteriosclerosis has been the chief cause of death in diabetics for several years and its incidence is increasing.

Coronary arteriosclerosis was the major cause of death in 51 per cent of a recent autopsy series (100 cases with onset of diabetes after age 21).

Acute myocardial infarction was present in 42 of the 100 cases and was the chief cause of death in 39 of these diabetics. About one-half of the 100 cases (49 per cent) showed one or more areas of old or new myocardial infarction.

Sixty-four per cent of the cases of acute myocardial infarction were females. This demonstrates that diabetes is a more important factor in the pathogenesis of coronary arteriosclerosis than are sex factors.

The very high incidence of myocardial infarction in diabetics is due mainly to an acceleration of the rate of coronary sclerosis, but the increased frequency of obesity and hypertension (usually related to nephropathy) also favors myocardial infarction.



LIBRARY OF THE COLLEGE OF PHYSICIANS OF PHILADELPHIA

FIG. 1. Graphic representation of the major causes of death in patients with onset of diabetes after age 21 based on 100 recent autopsies at the New England Deaconess Hospital (1948-1951). *Includes degenerative vascular lesions of the kidney and brain, and also pulmonary embolus.

The incidence of cerebrovascular disease in the diabetic does not differ greatly from its incidence in the nondiabetic.

Since renal infection accounted for 8.5 per cent of the deaths in this series, great emphasis should be placed on the discovery, prevention, and aggressive treatment of all urinary tract infections.

Pathologic evidence of intercapillary glomerulosclerosis is frequently seen in diabetes of long duration, but it is not frequently the cause of death in older diabetics. Vascular nephropathy (including intercapillary glomerulosclerosis) is, however, frequently a secondary factor in causing death in patients with onset of diabetes in adult life.

That the clinical course of juvenile diabetes is quite different from the course of adult diabetes may be demonstrated by comparing recent mortality statistics. The chief cause of death in juvenile patients are diabetic nephropathy (51.9 per cent), tuberculosis (11.9 per cent), diabetic coma (9.6 per cent) ;[1] while in diabetics with onset in adult life, the chief causes of death are coronary sclerosis (51 per cent), and cancer (18 per cent).

There is considerable recent evidence to show that careful control of diabetes will delay the onset of degenerative vascular lesions in younger diabetics. Investigation is needed to determine whether or not carful control of diabtes will postpone the development of coronary arteriosclerosis.

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PHARYNGEAL POLYP

ARTHUR H. DAVIS, M.D.

TULSA, OKLAHOMA

A white female, aged 19 years, was seen in July of 1947. Her complaint was a feeling of "something in her throat," gagging, vomiting and loss of weight. This condition had been noticed for the past two years. Her history was negative with the exception of a "head cold" five years previous to 1947, and a discharge of yellowish material from her nose for about six months. On several occasions, a whitish mass was regurgitated and was visible on top of her tongue.

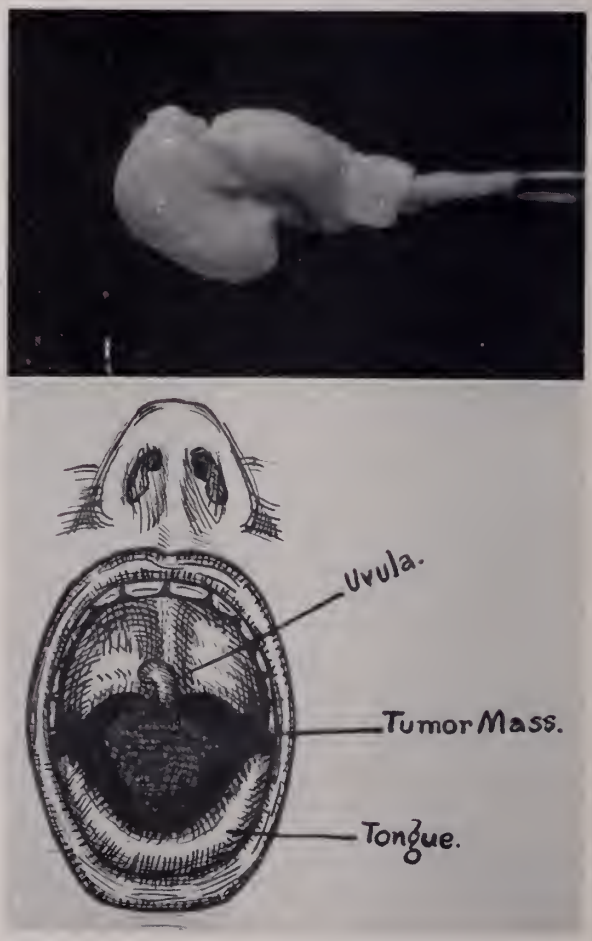
Examination showed the nose and ears were apparently normal.

Examination of throat showed a large glistening, white mass that extended behind the tongue into the hypopharynx. Following the examination, the nose was sprayed with a two per cent pontocaine solution. The pharynx also was liberally sprayed.

The distal end of the mass was pulled out until it rested on top of the tongue in close proximity to the teeth in front of the mouth. A snare placed through a tenaculum was passed over the mass, which extended into the nasopharynx and the mass was removed. The pedicle was attached to the left lateral wall of thenaso pharynx. There was some bleeding which was controlled by a post-nasal pack.

Brewer[1] reported a similar case with the exception his polyp was attached to the left side of the hypopharynx.

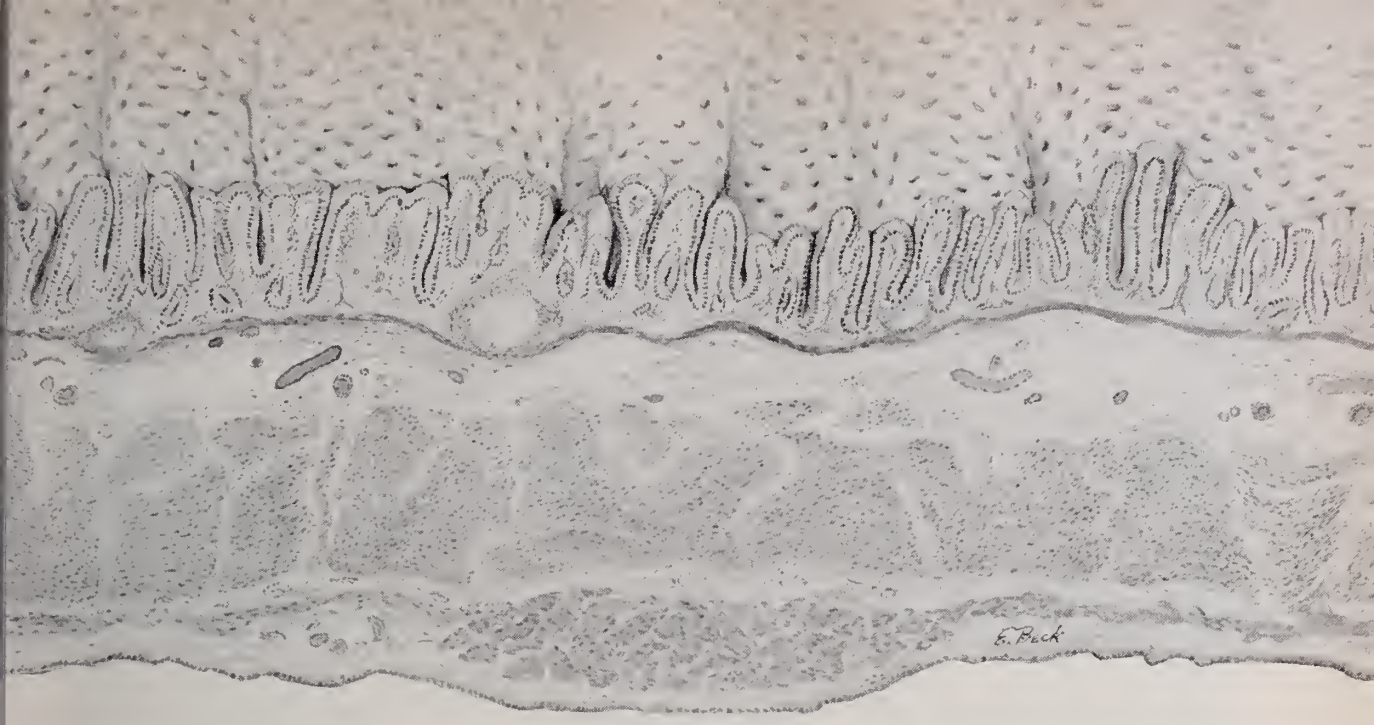
There has been no recurrence of her trouble since removal of the mass. Grossly the mass appeared as a white, glistening, polypoid-like substance which measured 7.5 × 3 × 1.5 cm. and was diagnosed as a benign polyp.



It is surprising even though this patient was from a rural community that medical attention was not sought until symptoms became more or less alarming to the other members of the family.

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Normal peristaltic action results from activity of the muscle layers as they are gently distended by bulk within the intestine; mucosal irritants cause overactivity of the muscle layers resulting in hyperperistalsis or spasm.

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Research in the Service of Medicine

President's Page

I had some doubts as to the wisdom of the State Association sending me as a representative on the Oklahoma Industrial Tour. Even after the Council approved the Executive Committee's recommendation, I all but backed out.

The Tour has just ended and I am glad to report that in my judgement it was well worth the effort. The Tour was well planned and well executed and I know of no more effective method of putting the resources and advantages of Oklahoma before the industrial world than by talking face to face with the top executives. We were loaded with factual information and the more than one thousand industrial concerns contacted received us with courtesy and often with enthusiasm.

For once, Oklahoma was advertised as a land of opportunity with educational, cultural, business and medical facilities on a par with the best and it was good to see them forced to give up their Cowboy and Indian concept of the state. The business men from all over the state seemed to appreciate the gesture by the Medical Association and I feel sure it was a worthwhile means of public relations at home.

All members of the State Association owe a debt of thanks to Dr. E. H. Shuller of McAlester. He went on his own and worked from morning 'til night every day — doing a swell job for us as well as the tour. Continued acceptance of our responsibility as citizens will pay off. Let's keep it up.

Alfred R. Sugg.

President



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NATION'S TOP BAND TO PLAY FOR DANCE AT ANNUAL MEETING

Ralph Flanagan and His Orchestra, currently America's Number One Dance Band in national popularity, has been selected to provide the music and entertainment at the President's Annual Dinner Dance, a feature of the 60th Annual Meeting of the Oklahoma State Medical Association to be held in Tulsa, April 13-15, 1953.

Flanagan, whose overnight rise to fame in 1950 has been climaxed by a record sale of over 3,000,000 phonograph records last year, will appear on Tuesday, April 14, to provide four hours of dance music and entertainment. Feature artists with the group include Harry Prime, former soloist with the Tommy Dorsey Orchestra, and The Singing Winds, top vocal and instrumental group.

Dr. William Orlando Smith, of Tulsa, Social Chairman for the 1953 Annual Meeting, said the location of the dinner dance will be announced later. An advance sale of tickets to the event will begin in March, and members of the Oklahoma State Medical Association will receive further information about the Dinner Dance prior to that time.

The Tulsa County Medical Society has announced that it will be host to the State Association at a social hour immediately preceding the Dinner Dance. A brief inaugural ceremony will follow the dinner and it is planned to eliminate formal speakers to insure a maximum of time for the Flanagan dance.

"We are very fortunate to secure Ralph Flanagan and his Orchestra," Dr. Smith said, "as the demand for his services is so great. We are sure every convention visitor will want to hear his splendid orchestra."

Flanagan appeared on the NBC and ABC radio networks last year for 44 weeks of sustaining air time. His RCA Victor record sales are now in excess of a million with his several "Rodgers and Hammerstein" albums taking top preference with record buyers. Young and personable, Flanagan has broken dance records at leading ballrooms over the nation. He begins a nation wide tour in January, having recently completed a long engagement at the famous Edgewater Beach Marine Room and Beachwalk in Chicago.

A complete program of convention activities is expected to be available for distribution in mid-February. Members planning to attend the 1953 Annual Meeting should write now for reservation to: Hotels Committee, Tulsa County Medical Society, 1202 Medical Arts Building, Tulsa, Oklahoma. Do not write hotels direct. Please state dates of arrival and departure and type of accommodation desired. Specify choice of hotels, (Mayo, Adams, Tulsa, Bliss, Albany).



RALPH FLANAGAN

Guest speakers for the 1953 convention will include.: Dr. W. Alton Ochsner, surgeon, New Orleans, La.; Dr. Garfield G. Duncan, internist, Philadelphia, Pa.; Dr. Francis J. Braceland, psychiatrist, Hartford, Conn.; Dr. Carl A. Moyer, surgeon, St. Louis, Mo.; Dr. F. Bayard Carter, obstetrician, Durham, N.C.; Dr. Allan Bloxsom, pediatrician, Houston, Texas; Dr. Wendell G. Scott, St. Louis, Mo.; Dr. James C. Sargent, urologist, Milwaukee, Wis.; and Dr. Paul H. Holinger, otolaryngologist, Chicago, Ill. One other speaker will be announced later.

SUGG IS CITED BY GOVERNOR

Alfred R. Sugg, M.D., O.S.M.A. President, has been cited by Governor Johnston Murray as the individual contributing most to the morale and enthusiasm of the members of the Oklahoma Industrial Tour. He has been commissioned a colonel on the Governor's staff.

The citation reads as follows:

"According to all reports you made a very vital contribution to this most important mission for the State of Oklahoma, and I want to personally thank you.

"The Industrial Tour was one of the greatest progroms undertaken to bring new industry to Oklahoma, and your contribution to this effort shall always be remembered by those with whom you worked."



Left to right: President Alfred R. Sugg, M.D. receives his citation from Governor Johnston Murray as George F. Lull (center), M.D., secretary-manager of the A.M.A. looks on.

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Five Receive Life Memberships

Five Oklahoma physicians received Life Membership certificates recently. They are D. S. Downey, M.D., W. H. Cook, M.D. and U. C. Boon, M.D., all of Chickasha; and Henry A. Ellis, M.D., Kiowa; and C. O. Williams, M.D., McAlester.

The Chickasha presentations were made by Councilor H. M. McClure, M.D., Chickasha, and Alfred R. Sugg, M.D., Ada, O.S.M.A. President, made the McAlester presentations.

Doctor Downey was born in Stewartsville, Mo. in 1878. He attended State Teachers College at Kirksville, Mo. two years and taught school five years before entering the medical department of the University of Louisville in 1903. Following his internship at St. Joseph Hospital in Louisville, he moved to Chickasha in 1909.

Doctor Cook was also born in Missouri, at Hartford, June 15, 1878. He graduated from Unionville Highschool and also attended Teachers College at Kirksville, Mo. He too taught school and then entered medical university, Columbia, Missouri in 1903. He graduated in 1906 from Washington University in St. Louis and came to Chickasha in 1909.

Doctor Boon was born in 1874 at Whiteright, Georgia. He attended the University of Texas and was graduated from Tulane University in 1898. He has been practicing ENT in Chickasha since 1913.

Doctor Ellis, who has been mayor of Pittsburg for 15 years, was born February, 1876, in Mississippi. He was married in 1901 and has six children, four boys and two girls. Doctor Ellis began practicing in Birmingham, Alabama, and came to Oklahoma in 1902 locating first in Savannah. He has lived in Pittsburg, Okla. for 25 years and has had an office in Kiowa, Oklahoma for 22 years.

Doctor Williams was born August 18, 1882 and came to Oklahoma in 1907. He graduated from Vanderbilt University in 1907. He located first at Talihina and came to McAlester in 1916. Doctor Williams has three children.



Top: Henry A. Ellis, M.D. and C. O. Williams, M.D., receive their Life Membership certificates from President Alfred R. Sugg, M.D. (center).

Lower: W. H. Cook, M.D., U. C. Boon, and D. S. Downey, M.D. (left to right) are shown with H. M. McClure (right) after the presentation at Chickasha.



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CURRENT ACTIVITIES AT THE OKLAHOMA MEDICAL RESEARCH FOUNDATION

EDWARD C. REIFENSTEIN, JR., M.D.
DIRECTOR



This article, the fourteenth in the series, discusses the plans for continuing the financial support of the Foundation.

The initial Foundation campaigns resulted in received and pledged funds totaling approximately $2,100,000.00. This money has been utilized during the past four years in providing salaries for the administrative, maintenance and scientific staffs (now nearly 60 persons); and in purchasing large quantities of permanent equipment and consumable supplies needed in the investigative program. These funds have been augmented by institutional grants (which aided in the construction of the Research Hospital and in the organization of some projects), by designated bequests (which have been utilized for the purchase of large pieces of equipment, and for initiating specific investigations), and by grants-in-aid (which have made possible the other research projects). These contributions and awards have come from philanthropic individuals and from a number of national fund granting organizations.

The financial reserve at the present time has dwindled to the point where almost the entire amount available for research studies is being obtained from these grants-in-aid from outside organizations. Therefore, these agencies, by their acceptance or rejection of applications from the Foundation staff for such grants, determine the research program that can be supported at the Foundation. This situation will continue until the citizens of Oklahoma, through their voluntary contributions of undesignated funds, make it possible for the Foundation to supply at least 51 cents out of each dollar that is spent on a specific study, and at this point the Foundation will control its own research activities. Furthermore, the shortage of undesignated funds makes it very difficult for the staff to continue certain activities such as the alterations to make room for new equipment, the installation of such equipment, the maintenance of existing facilities, and similar fundamental and essential operations.

For these reasons, plans have been prepared for a financing program to provide permanent sustaining support of the Foundation research activities. It should be noted that even when such sustaining support is available, it is the intention of the scientific staff to continue efforts to secure as much financial aid from outside agencies as is consistent with keeping control of the research program in the Foundation.

A careful review of the research program indicates that at least $300,000.00 a year is required from Foundation funds to maintain the investigative activities at the desirable level. The broad financial plan is based on this estimate. It is hoped to secure within the next three-year period sufficient funds to meet the annual maintenance budget for at least six years of operation. During the second three-year period of this six-year plan, intensive efforts will be made to secure permanent endowment of sufficient magnitude so that by the end of the six years, the annual income form the endowment will meet the costs of continued operation.

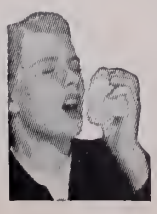
As the first step in the financial campaign, a survey was conducted by a specialist trained in the field of financial campaigns, Mr. Reginald Cumerford, a member of the administrative staff of the Foundation, who visited physicians and lay persons in a number of areas throughout the State. From his findings it appeared that a campaign was feasible although additional effort was needed to educate and interest the citizens of the State in such a program.

Since the fall of 1952, therefore, an intensive public relations effort through all channels has been acquainting the citizens of Oklahoma with the development and program of the Foundation. Newspaper releases, radio and television announcements, and lectures have been utilized for this purpose. The administrative group, who are spearheading the campaign, have been wholeheartedly supported by the scientific staff. During one month alone, each of eight members of the research staff gave an average of three talks to lay organizations, service clubs, and medical societies, and traveled to many parts of the State for luncheon and evening meetings. Many groups of persons have made inspection trips and guided tours of the Foundation facilities, and the technical personnel of the Institute staff have been especially trained as guides. An "Open House" was held October 26, 1952, commemorating the opening on September 3, 1952 of the Research Hospital. A series of articles on the Foundation has been published monthly in the Journal of the Oklahoma State Medical Association; a reprint of one of these has been sent to many of the physicians in the State.

The fund-raising program is divided into four phases: 1) a campaign for previous donors of substantial gifts; 2) a campaign for potential donors of substantial gifts; 3) a campaign for the general public; and 4) a campaign for wills and bequests. While all campaigns will be conducted to some extent simultaneously, the emphasis during the first three-year period will be placed on phases one and two, and attention will be given to phases three and four later as the educational program brings greater understanding of the development and program of the Foundation to the citizens of the State.

The previous donors of substantial gifts are being contacted at the present time. This group includes individuals or firms who have pledged or paid in cash in the amount of $5,000.00 or more. The objectives are to collect those pledges which are still unpaid, and to secure from as many of these donors as possible a substantial increase in their pledges with a reasonably prompt payment of the additional contribution.

A sizable program has been developed for the solicitation of potential donors of substantial gifts. By uti-



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lizing many contacts, lists of donors have been prepared and their potentials for contribution have been thoroughly assessed. Two visitation teams, one of lay individuals and one of physicians, have been chosen with great care. Each of these teams includes over 36 persons, and each of the members has agreed to give one full day per month for visitation, after having spent one full day at the Research Institute and Hospital in being briefed on the administrative and scientific aspects of the program. The members of these two teams, paired so that a lay person and a physician work together, will visit the potential donors. Those team members with the most influence on the potential donor will be selected for each prospect. The visitations will be carefully scheduled, and will be continued until all of the potential donors either have joined the Foundation or have been eliminated. Previous experience indicates that three to five calls on a potential donor may be necessary before his final decision is made.

The executives and governing groups of the Foundation recognize that health is everyone's business, and thus that everyone must have an interest in health, in medicine, and hence in medical research. Therefore, at the proper time, the campaign will be carried to the general public. A system of having continuous donations of a small nature is planned. This will be organized by counties, and will center about cardboard containers, with an appropriate message and a plastic test-tube large enough to receive coins up to the size of a half-dollar, which will be placed in the offices of physicians, dentists, pharmacies, drug stores, and banks throughout the State. The short comment on the cards will be changed each month, and the coins will be collected monthly by the county organizations. During the periods when annual campaigns are conducted for cancer, heart, or polio funds the message will indicate that the coins will go to the appropriate agency; during the remainder of the year, the money will go toward the general activities of the Foundation. A campaign of this type is based on the philosophy of "Little drops of water make a mighty ocean," and is designed to reach many thousands of persons at strategic places and times. No goals will be set in this part of the campaign.

The last phase of the program deals with wills and bequests. The Foundation staff already are aware of several donations that have been included in wills by by citizens of Oklahoma. These provide a basis for an endowment fund to sustain the Foundation in the future. Information concerning contributions of this type has been sent to all of the attorneys, physicians, dentists and bank trust departments throughout the State. The distributed material has been approved by the Foundation's attorney and also by the President of the State Bar Association. Additional information will be sent to all of these groups periodically. Special teams will visit potential benefactors as they are made known to the staff of the Foundation.

Every citizen in Oklahoma deserves the very best of medical care to regain, maintain, and preserve his health. To accomplish this, all physicians and members of allied healing arts must be alerted to the fact that the frontier of medical research resides with them. Their critical evaluation of the problems of those who consult them professionally can lead to significant advances in medicine. This critical attitude will be fostered and encouraged by the Oklahoma Medical Research Foundation, as a focus from which attacks upon disease and improvements in the healing arts can spread throughout the State. The Foundation can realize this vital potential only when each citizen is conscious of his obligation to help medical research in order to help himself.

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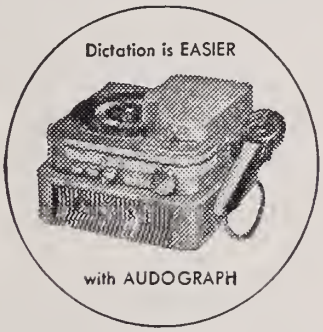
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OBITUARIES

ALONZO JEDSON WILLIAMS, M.D.
1879-1952

Alonzo Jedson Williams, M.D., who practiced in Pottawatomie county for 46 years, died November 9 in an Oklahoma City hospital.

Doctor Williams was born at Antioch, Georgia, and came to Oklahoma immediately after finishing medical school at Emory college, Atlanta, Georgia. He also held degrees from colleges at Memphis, New Orleans and Kansas City.

He came to Dale in 1906, later moving to McLoud where he practiced until 1946 when he moved to Shawnee. Doctor Williams was a World War I Veteran, a member of the Baptist church, and Masonic lodge.

THOMAS GORDON FORSYTHE, M.D.
1896-1952

Thomas Gordon Forsythe, M.D., practicing physician at Allen for more than 25 years, died November 8 in an Ada hospital.

Doctor Forsythe was born January 27, 1896 in St. Louis, Mo. He was graduated from the University of Oklahoma School of Medicine in 1926. He was a member of the American Legion, the Allen Masonic Lodge and McAlester Consistory.

Survivors include two brothers and one sister.

JESSIE LEE BLAKEMORE, M.D.
1862-1952

Jessie Lee Blakemore, M.D., who came to Muskogee in Indian Territory in 1892 and remained a practicing physician for 57 years before his retirement in 1949, died at his home November 4 following a heart attack.

Doctor Blakemore was born in Greenwood, Ark. He graduated from Emory and Henry College in 1885 and in 1886 enrolled in Memphis Hospital College. He then enrolled in Vanderbilt University Medical School, graduating there in 1888 and practiced in Greenwood, Ark. until he received an appointment to the Arkansas Mental Hospital where he remained until he came to Muskogee.

In Muskogee he helped organize and was a charter member of the Muskogee Country Club. Later he was active in the organization of the Wauhilla club. He belonged to all Masonic bodies of Muskogee and was a member of the Presbyterian church.

He is survived by the widow of the home, two sons, one daughter, a sister, seven grandchildren and three great grandchildren.

JESSE CARNES BEST, M.D.
1887-1952

Jesse Carnes Best, M.D., Oklahoma City, died Nov. 4, enroute to a hospital.

Doctor Best was born in Collin County, Texas. He did his undergraduate work at the University of Oklahoma and attended medical school at Baylor University and interned at the Baylor University hospital. He was a member of the Christian church and Masonic lodge.

He is survived by his widow of the home, two sons, one brother and two grandchildren.

ASA MARTIN ARNOLD, M.D.
1864-1952

Asa Martin Arnold, M.D., a resident of Claremore for more than 40 years, died at his home there October 20 following a heart attack.

Doctor Arnold came to Claremore in 1913 from Jackson, Kentucky. He was a graduate of the medical school at the University of Louisville. He retired from practice about two years ago.

Survivors include the widow of the home, one son and two daughters.

JOHN R. CALLAWAY, M.D.
1876-1952

John R. Callaway, M.D., Pauls Valley, died November 3. Death was attributed to leukemia.

Doctor Callaway had practiced in Pauls Valley since 1921, having previously practiced in Elmore City. He graduated from St. Louis University. Doctor Callaway was a member of the First Christian church, Masonic Lodge, American Legion and had been presented an O.S.M.A. Fifty Year Pin.

Doctor Callaway is survived by his widow of the home, one son, three sisters and two grandchildren.

HAVE YOU HEARD?

Bill J. Simon, M.D., Perry, discussed socialized medicine at two rallies in Noble county prior to the election.

F. Redding Hood, M.D., Oklahoma City, chairman of the Oklahoma Volunteer Advisory Committee for Physicians, Dentists and Veterinarians, was guest speaker at a meeting of the Oklahoma State Nurses Association held at Lake Murray.

Thelma Varian, M.D., Wagoner, attended a meeting in Omaha recently.

Anne C. Courtright, M.D., is the new assistant director of the Oklahoma County health department.

Charles F. Moore, M.D., Durant, is the new department medical adviser of the American Legion.

Ray H. Lindsey, M.D., Pauls Valley, and *Jack T. Terry, M.D.,* Ponca City have been attending a postgraduate course at the Cook County Graduate School of Medicine.

Laurence O. Short, M.D., has been appointed acting director of the Tillman County Health Department.

Harold Baugh, M.D., Meeker, has been appointed county superintendent of health of Lincoln County.

J. R. Colvert, M.D., Oklahoma City, discussed "The Business Man's Indigestion" at a Kiwanis club meeting.

F. M. Adams, M.D., for 39 years medical superintendent of the Eastern State Hospital at Vinita, was recently honored by the Tulsa County Health and Welfare Association.

Charles H. Wilson, M.D., Oklahoma City, is the new president of the Uptown Kiwanis Club of Oklahoma City.

H. V. L. Sapper, M.D., and *Bertha Levy, M.D.,* both of Oklahoma City, have been elected to fellowships in the American Academy of Pediatrics.

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GUESTS OF ELI LILLY AND COMPANY



Pictured above are Oklahomans, Physicians and their wives who recently visited Eli Lilly and Company of Indianapolis. While guests of the company, they inspected the Lilly Research Laboratories and toured pharmaceutical, biological, and antibiotic production facilities.

MEET OUR CONTRIBUTORS

Bert E. Mulvey, M.D. and Bob J. Rutledge, M.D. have an article in this Journal on "Regional Enteritis Isolated to the Jejunum: A Report of Two Cases." Doctor Mulvey, who practices in Oklahoma City, was graduated from the University of Oklahoma in 1930. His specialty is radiology and he has been certified by that board. He is a fellow of the American College of Physicians and a member of the American College of Radiology. Doctor Rutledge was graduated from the University of Oklahoma in 1948 and his specialty is neurosurgery. He is a resident in neurology and neurological surgery at the Illinois Neuropsychiatric Institute of the University of Illinois College of Medicine. He served as rotating interne in the Kansas City General Hospital in 1948 and 1949 and was in the navy during 1950 and 1951 and later was senior resident in general surgery at St. Anthony's Hospital, Oklahoma City and later resident in neurological surgery at the University of Oklahoma Hospitals.

Kelly M. West, M.D., Oklahoma City, and *Howard F. Root, M.D.*, Boston, are joint authors of "Increase of Coronary Arteriosclerosis in Diabetes Mellitus" in the January issue. Doctor West, who has recently established his practice in Oklahoma City, was graduated from the University of Oklahoma in 1948. His specialty is internal medicine. He was formerly instructor at the University of Michigan Department of Internal Medicine and was a fellow at the Joslin Clinic in 1950-51. Doctor Root was graduated from Harvard Medical School in 1919 and his specialty is internal medicine. Doctor Root has been certified by the Board of Internal Medicine and is a member and former president of the American Diabetes Association and a member of the American Heart Association, Society for Clinical Investigation, American Clinical and Climatological Society and the Endocrine Society. He is a member of the Council of the Massachusetts Medical Society and chairman of the Committee on Diabetes, Massachusetts Medical Society.

Arthur H. Davis, M.D., Tulsa, has a case report on "Pharyngeal Polyp," in this issue. Doctor Davis, whose specialty is E.E.N.T., was graduated from the University of Louisville School of Medicine in 1919. He is a fellow the American College of Surgeons, Fellow of the American Academy of Ophthalmology and Otolaryngology and a Diplomate of the American Board of Otolaryngology.

ANNOUNCEMENTS

The Department of Anesthesia of the University Hospitals, Oklahoma City, Oklahoma, is continuously conducting an informal postgraduate training program for physicians. There will be no formal classes. The individual physician will be given clinical instruction in any and all anesthetic techniques in which he is interested, with side lights on premedication, the treatment of complications, related physiology and pharmacology and any other perinent subject.

This course will be conducted in Oklahoma City at the University Hospitals. It is designed primarily for physicians in smaller communities.

We will be able to take care of one physician at a time and for any period of time the candidate can afford to spend. An attempt will be made to arrange the schedule to suit the convenience of those physicians desiring to attend.

There is no tuition fee for this course.

Physicians interested should write to Howard A. Bennett, Chairman, Department of Anesthesia, University Hospitals, Oklahoma City 4, Oklahoma, for further information and scheduling.

BOOK REVIEW

TEXTBOOK OF SURGERY. Edited by H. F. Moseley, forward by G. G. Miller, Published by C. V. Mosby, 1952. Pages: 896, Illustrations: 426, Color Plates: 60.

This extremely well organized and well written textbook on surgery comes out of McGill University, Montreal, Canada. The many contributors are for the most part from the staff of McGill University and the Royal Victoria Hospital. The text is very up to date in all its sections and is highlighted throughout by sixty very excellent color plates. The illustrations are large and very informative. In fact, a little superior to our American publications in this respect. Such subjects as radioactive iodine, potassium therapy, hypersplenism, and most all recent antibiotics are covered extremely well in this text.

It is always refreshing to read Canadian aud British medical writing as they have a way of expression characterized by simplicity that many of our own authors seem to lack. I think this textbook should be included in the library of every general surgeon and I highly recommend it.—Everett B. Neff, M.D.

FILM AVAILABLE

A film on the health of the school child is being produced by the State Department of Health with the guidance of the State Medical Association, State Health Council, and State Department of Education. The elements of a school health program have not been too clear to many people. The American Medical Association has sponsored a number of national conferences which have done much to set out these elements. This film along with the workshops which have been held in connection with the School Administrators Conferences at the University in the past two years will help to clarify in the minds of the medical profession, public health workers, and school people the aims and objectives of such a program.

The film is in color and promises to be interesting and instructive. It should be ready for showing by January 15 or soon thereafter.

CLASSIFIED ADS

DOCTOR WANTED: Northwest Oklahoma. About 2,500 population to draw from. Nearest medical doctor or hospital 22 miles. Write Key V, care of the Journal.

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THE JOURNAL
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EDITORIALS

HOSPITAL AND MEDICAL SCHOOL COSTS

Ever mounting agitation about the cost of medical education and hospitalization has led to the question of Federal subsidy and government control. That this is not the answer is suggested by the long existing relatively high cost of maintaining our own federal hospitals.

Perhaps of greater significance is the experience of Britain's Ministry of Health under the existing National Health Service Act of 1948. Since the act went into effect, there has been more publicity about the overstaffing of hospitals and the rising costs.

The November 22 issue of the *British Medical Journal*[1] carries two significant editorials bearing on the costs of hospitals and medical education: 1. Reduction of hospital staffs. 2. Social medicine at Oxford. Under the first we learn with no surprise that the ". . . hard pressed officials of the Ministry are having to carry out the Treasury instructions," in spite of the fact the hospital enployees should ". . . feel that they are copartners in a joint enterprise and not just casual labor to be hired and fired according to the latest rule of the Treasury." Should not medicine and government in the United States be forewarned by Britain's present predicament.

How familiar the first sentence in the following quotation sounds to those who have been watching the growing centralization of power in our own government. And how important it is for us to contemplate the continuing tone of this editorial as it closes with the sad note of the Ministry's promises:

"What is to happen to those whose jobs will be thus brought to an end? The boards are obliged, Sir Russell points out, to find them alternative work, but even then, can anyone, least of all those affected, feel happy about the situation which has been allowed to develop? Will the boards be able to find alternative work in the face of an all round reduction of staffs? It is the answer to these questions which many will want to know, questions which consultation with the profession might have helped to answer in advance. The young and coming generation of consultants must reflect somewhat cynically on the exaggerated promises made by politicians in particular before the Health Service came into operation. There was then foretold in glowing terms the widely opening opportunities for consultants and specialists in the National Health Service. An increase by as much as 50 per cent was foreseen by some well-known apologists. The present incident to which Sir Russell draws attention is yet another illustration of the dangers of centralization. Those who are pressing for decentralization in the administration of the hospital services will be encouraged by this to redouble their efforts."

The editorial indirectly referring to medical education has to do with the closure of the Institute of Social Medicine at Oxford University. Economy demanded a review of its relative importance and its fate is well told in this paragraph:

"When the Institute of Social Medicine was founded at Oxford in 1942 the Nuffield Provincial Hospitals Trust made a grant of 100,000 pounds to cover the expenses of the Institute for 10 years. The grant has now come to an end, and the Board of the Faculty of Medicine at Oxford has recommended that the study be continued but at a lower level of expenditure, with a reader but without an institute. Evidently the board has had the difficult task of having to decide whether to abandon the institute or to cut down on other more vital projects. In a letter in which he discussed this dilemma Professor A. D. Gardner pointed out that, if Oxford were to ask the University Grants Committee to earmark a grant specially for social medicine, this 'would falsely imply that social medicine is of such unique importance to us that we must secure it whatever happens to other subjects.' Hard economic facts cannot be

ignored and doubtless the decision of the Board of the Faculty of Medicine was inevitable, but all who have an interest in Medicine in its widest aspects will deplore the passing of the Oxford institute."

1. *British Medical Journal.* No. 4794. Saturday, November 22, 1952. Page 1140.

SOCIALISM AND COMMUNISM

Apparently the leveling process is sweeping the world. Wherever it prevails, intelligence is imprisoned, incentive is throttled and personal initiative is usurped by the state.

What a dreary world with neither rich nor poor, good nor bad, wise nor foolish. What a grim level on which to live. What an asphyxiating atmosphere with no hope of resuscitation. Even hell has its gradations. Such an existence would be worse than Dante's lower circle.

Though we no longer have to carry our guns to the field to save our guts while we make corn for our grits, we are threatened with a fate that would be much worse than being shot on the spot.

Physicians should be the first to recognize the danger, set their stakes and lift their sights. Through education and public relations they should lead the fight against the annulling influence of this vicious political philosophy that is killing the world.

KNOWLEDGE, REASON AND JUSTICE

An informed judge, United States Circuit Court of Appeals, reasoning logically, puts the Hoxsey Cancer Clinic of Dallas out of business.

In medicine and in law, "a little knowledge is a dangerous thing." The Texas trial judge deficient in medical knowledge said, "Some it cures and some it does not cure, and some it relieves somewhat." The Judge of Appeals Court, after discussing tissue diagnosis of cancer, had the wisdom to say, ". . . the opinion of a layman as to whether he has cancer or whether he has been cured . . . is entitled to little weight.".

In the *Journal* of April, 1947, there is a long discussion of the Hoxsey hoax.

How long it takes for knowledge to sink in! How long for justice to arise! Thanks to a wise judge. Congratulations to all frustrated cancer victims. Goodbye, Mr. Hoxsey.

A TIP FOR THOSE IN CHARGE OF ADMISSIONS TO MEDICAL SCHOOLS

In Louisville, Kentucky, 1852, the first President of the Kentucky State Medical Association, William Loftus Sutton, giving advice to prospective preceptors, said:

"The private physician should absolutely refuse to receive into his office for instruction, any young gentleman whose natural intellect, moral character, and previous academic training, do not afford grounds to believe that he will make a respectable member of the profession."

THE CONSUMMATE DANGERS OF EDITORIAL COUNCIL

In the famous tragedy, "Antigone," Sophocles wrote, ". . . of all curses which cleave to man, ill council is the sovereign curse." Fortunately, the readers of the *Journal* are of such intellectual caliber they need not be informed of the heavy responsibility resting upon the shoulders of the *Journal's* Editorial Board. The Board must determine policies and accept responsibility for what is printed in the editorial columns. But, fortunately, for the members of the Editorial Board, the readers because of education and experience so nearly approach "the mature mind" they may be further informed but not too readily influenced by editorial pronouncements. Yet in view of the November national landslide including the surprising Oklahoma avalanche the Journal and its Editorial Board and the staff at the Executive Office of the State Association may with a certain degree of pride look forward to the death of the New-Fair-Deal when Eisenhower takes over January 2.

To some extent the belated political revolution may be considered as a justification of our long continued editorial policies against entrenched, power mad, bureaucrats in Washington and a vindication of our avowed cause, the freedom of both patient and physcician in their professional relationships, considering the socialistic psychology of the masses, the battle must continue.

So with the curse of ill council ever before us the Editorial Board carries on. Though reader council is subject to the same curse, please remember we crave constructive criticism even though it cleaves to the core.

Scientific Articles

BUTAZAOLIDIN IN RHEUMATIC DISEASES

E. GOLDFAIN, M.D.
OKLAHOMA CITY, OKLA.

At the June, 1952, American Rheumatism Association convention preliminary reports on Butazolidin therapy were given by several workers. They observed favorable effects in rheumatic conditions such as gouty arthritis, Marie-Strumpel spondylitis, psoriatic arthritis and to some degree in osteoarthritis.

Some rheumatoid arthritis cases obtained good relief. Others did not react favorably. Fibrositis cases, such as muscular rheumatism, bursitis, neuralgias and periarthritis experienced good pain-relieving effects.

These clinical results substantiated impressions observed when this drug was used in animals after its synthesis by the Geigy Laboratories. The animal studies revealed Butazolidin to have usefulness in the relief of painful musculoskeletal disorders. Strong analgesic and antipryretic properties were noted, as well as an "anti-inflammatory" effect. The "anti-inflammatory" effects were delay and reduction of local tissue reaction produced by chemical and physical irritants.

The manufacturer reports a high degree of drug tolerance, as shown by toxicity studies in animals. Butazolidin, first used in Europe, was found quite efficacious in relieving rheumatic conditions as outlined. In the United States, Butazolidin has been subjected to intensive clinical investigations approximately two years. Papers read at the American Rheumatism Association meeting indicated that Butazolidin can produce prompt and prolonged relief from pain. On pain relief, musculo-skeletal tissue mobility is increased. Spasm is reduced. Dimunition of swelling also occurs in some cases.

A majority of the cases treated reacted favorably. Fortunately, its good effects are manifest within a period of two to four days. If a patient does not experience relief within a week, Butazolidin therapy should be discontinued. To use larger therapeutic doses where improvement is not thus observed carries a serious risk of producing toxic side reactions. When maximum relief has occurred, Butazolidin dosage reduction to minimally effective amounts is indicated. Such therapy procedure minimizes occurrence of side reactions; for one consciously accepts a serious hazard when using this drug. Furthermore, there is no proof that it has curative values. Thus far, medical reports do not make such claims.

We have been using Butazolidin since the reports were made at the American Rheumatism Association convention. Very close supervision is maintained over these cases. Laboratory tests are made at frequent intervals. Thus, reactions are promptly detected, and medication is immediately interrupted. Use of this drug without close personal supervision, plus adequate laboratory check-up is not warranted. Danger of serious side reactions occurring, with grave results to the welfare of the patient may otherwise results. Butazolidin should be used only in cases that do not respond to present tried and proven treatment procedures. As yet,

LIBRARY OF THE

Butazolidin is simply one more weapon in rheumatologic therapy.

Serious side reactions to be carefully watched for in Butazolidin medication are:

1. DRUG RASH: A very few of the patients experienced a drug rash. Medication interruption produced its disappearance.
2. NAUSEA: The drug is best given on a full stomach. Some can take Butazolidin without nausea, even on an empty stomach. If nausea appears, an antacid will help, such as magnesium hydroxide, or calcium carbonate.
3. EDEMA: Edema has occurred in two of our cases thus far. It cleared quickly upon withdrawal of Butazolidin.
4. SODIUM: Salt intake should be restricted. Butazolidin tends to cause sodium retention, with resulting localized or generalized swelling. It should not be used in patients with cardio-vascular, renal or hepatic difficulties.
5. PEPTIC ULCER: As yet, no patient has reacted with peptic ulcer activation. The medication should not be used in individuals with active peptic ulcer or with duodenal ulcer history.
6. ABDOMINAL CRAMPS: Marked abdominal cramping may occur in patients taking Butazolidin. Persistent abdominal cramping may necessitate addition of a non-sodium-containing antacid. Butazolidin discontinuance may become necessary. The patient may stop the drug because of cramping.
7. AGRANULOCYTOSIS: In our experience agranulocytosis, thus far, has not appeared in those on Butazolidin therapy. A few cases have reacted with a mildly-moderate fall in the neutrophile count. Temporary elevation of the white blood cell count was noted in three cases. The particular chemical structure of this drug requires frequent white and differential cell counts. Any indication that the granulocyte count is being definitely reduced, calls for immediate Butazolidin interruption. *In some personal communications I have received, three severe agranulocytosis cases have been observed.* They had not responded adequately to the drug withdrawal at the time the communications were written.
8. CHEMISTRY: The chemical structure of Butazolidin is such that in due time, if the medication is used without proper supervision, bone marrow toxic effects may result. It should be given with extreme caution.
9. SECONDARY ANEMIA: In our experience a troublesome factor has been a secondary anemia production. There develops a definite reduction in the red cell count and hemoglobin determination. This has not been sufficiently emphasized. It points up the urgent need for frequent red and white cell counts. Laboratory checkup tests are done weekly the first six weeks of treatment; thereafter, every ten days; and later twice a month.

Butazolidin therapy, for best effects, should not be used persistently for weeks or months, but over a period of days. Intervals of non-treatment should alternate with Butazolidin treatment periods.

When a patient has not derived benefit from Butazolidin therapy in four to seven days, it should be discontinued. He who does not get good results from it should not be pushed to larger and larger dosages. It should be promptly stopped.

SUMMARY

Butazolidin (Phenylbutazone) is still in process of being evaluated as a therapeutic drug in rheumatic disorders. Inasmuch as serious side reactions may occur, it should be given only under the close personal supervision of the physician. Frequent laboratory examinations of the red and white blood cells are imperative.

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PERITONEAL BANDS OF NON-SURGICAL ORIGIN

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TULSA, OKLAHOMA

Since Virchow's[1] comprehensive report, published in 1853, the frequent occurrence of intraperitoneal bands has been noticed by all pathologists and by most surgeons. Harris,[4] writing in 1914 on duodenal obstructions, apparently was the first in this country to notice the problem of abnormal peritoneal bands. Following this treatise there were a number of articles published which were primarily concerned with the entity titled "gastro-intestinal stasis." This condition appears to have been quite fashionable in surgical circles during the first two decades of the present century, enjoying considerable attention from such leading men of that time as C. J. Mayo, the elder Coffey, Arbuthnot Lane, Franklin Martin *et al.* Suffice it to say that these observations have become of interest mainly from a historical standpoint. In more recent years there has been a resurgence of interest in certain types of peritoneal bands, particularly the hepatoduodenocolic band of Harris, and excellent papers regarding this anomaly have been published by Solem,[5] Taylor,[6] Kantor[7] and Mahoney.[8]

Bryant[2,3] who has made the most accurate and valuable observations in modern literature concluded that the frequency of peritoneal bands has been greatly under-estimated. In his series of cases he found bands present in 91 per cent of the males, which included 18 fetuses. He also observed the same frequency of involvement of the various types of bands in both fetuses and adults. This finding seemed to confirm the development origin of these bands or "adhesions." His findings are summarized as follows: 1. The transverse colon is more frequently involved by adhesions than any other abdominal viscus. 2. Within a range of variation not usually exceeding 10 per cent, the rate of involvement of a given viscus may be greater in the male or in the female, and this relative rate of involvement in regard to sex may further vary with age. 3. The rate of involvement by adhesions, is for several viscera higher in the fetus than at later ages, as for the transverse colon in the male and the terminal ileum in the female. 4. The rate of involvement by adhesions increases rapidly with progressive age for certain other viscera, as for the sigmoid flexure in the male and the adnexa in the female. 5. The age of 40 is critical in both sexes with reference to the average number of viscera involved by adhesions in any given case. After the age of 40 there is a sudden increase of involvement by about 50 per cent in both sexes, the increases being somewhat more marked in the male than in the female. 6. Complexity is practically a synonym for age, with regard for the number of viscera involved in any given adhesive process. This increase in complexity amounts to over 200 per cent after forty years of age. 7. Variety in the character of the adhesions present also increases with age. A sudden marked increase of nearly 100 per cent occurs in the 30-40 year decade, or 10 years earlier than the onset of the marked increase with regard to the average number of viscera involved, and the onset of the increase in the complexity of the adhesions themselves. 8. The distinguishing characteristics of congenital or developmental adhesions, are simplicity and lack of variety in type. 9. The distinguishing characteristics of acquired adhesions, are complexity and variety in type.

CASE REPORTS

Case 1: Mrs. E. P., white, age 50, was admitted to the hospital complaining of agonizing paroxysms of abdominal colic. The preceding night she had developed some mild abdominal pain which she attributed to an



FIG. 1. (*Case* 1.). *The genito-mesenteric fold of Reid is seen passing over the terminal ileum and cecum and extending upward toward the duodenum.*

"upset stomach." During the night this progressed to become severe paroxysms of cramping located in the para-umbilical and left suprapubic regions. She had little or no nausea but tried to induce vomiting in the hope that this might bring relief. Her bowels had always been regular and she had never noticed any abnormal stools. By dieting she had maintained her weight at around 100 pounds. She had had two normal full-term pregnancies. She had had no other illness than the usual ones of childhood. There was no history of previous operations or of injury to the abdomen. A complete review of the body systems was negative except as indicated above.

The physical examination was negative except for the abdomen. This was very slightly distended. There were no operative scars present. The recti were not rigid and no masses or enlarged organs could be felt. Diffuse tenderness was present throughout the abdomen but was most marked in the suprapelvic area and in the right lower quadrant. Slight rebound tenderness was present in the latter area. Auscultation revealed peristaltic rushes and increased borborygmi. When the finger was inserted deeply into the rectum a tender mass could be felt. Vaginal examination was negative except that a second degree retroflexion was present and manipulation of the cervix caused reproduction of the primary pain. A scout film of the abdomen gave no useful information and the routine laboratory examinations were normal except for a leucocytosis of 12,500 of which 88 per cent was polymorphonuclear cells.

The diagnosis was acute intestinal obstruction, possibly due to volvulus of the small intestine, and laparotomy was performed under spinal anesthesia about 20 hours after the onset of this patient's illness.

Through a left para-median incision the peritoneal cavity was opened. A large quantity of sero-sanguinous fluid welled out of the opening and the small intestine was moderately distended. A loop of greatly distended and dark plum-colored ileum was seen in the depth of the pelvis. Further inspection showed a mesenteric band extending from the root of the iliac mesentery to the posterior surface of the right utero-sacral ligament where it merged with the lower uterine segment (Figure 1.). This was completely obstructing a loop of ileum approximately 20 cm. long at a level about 15 cm.

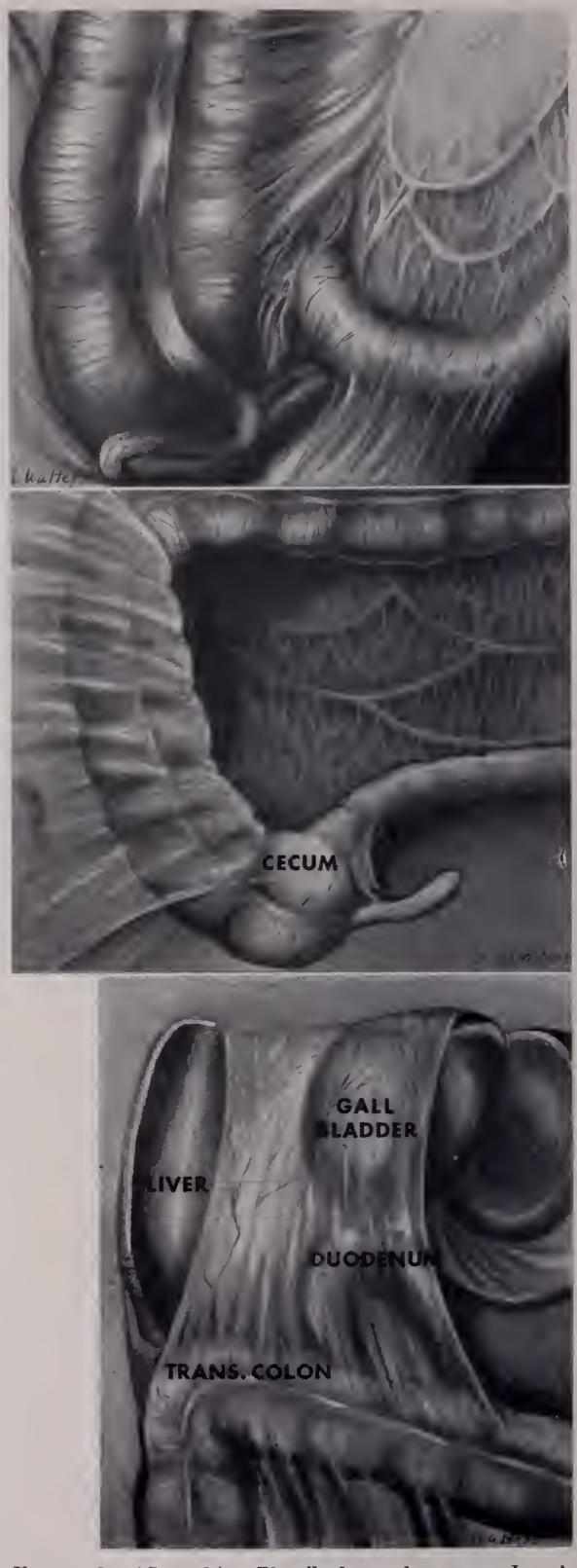


FIGURE 2. (*Case 2.*). *The ileal membrane, or Lane's Fold.*

FIGURE 3. *Jackson's Veil, or pericolic band.*

FIGURE 4. *The cholecystoduodenocolic membrane. The anterior liver edge is retracted upward to show the important relationships of the band.*

above the ileocecal junction. This constricting band was severed and the strangulated portion of bowel was packed for 25 minutes with very hot wet laparotomy pads. The color of the bowel segment improved markedly, so, after removing a normal appendix, the abdomen was closed without drainage.

The patient made an uneventful recovery and was dismissed from the hospital on her eighth post-operative day. At the time of this writing, three years later she had had no further difficulty.

Case 2: Mrs. J. McK., white, aged 52, was admitted to the hospital complaining of abdominal pain, nausea and vomiting. Five days prior to admission she had eaten some fried cabbage which was vomited after a few hours. The following day she developed some mild cramping pains in the abdomen. An enema produced a fairly copious bowel movement but the pain gradually became worse. Three days later she was first examined and at this time she was vomiting incessantly and had had no bowel movements. The abdomen was diffusely moderately enlarged and was tender throughout. No masses could be felt superficially or by vagina or rectal examination. X-ray following a barium enema revealed an obstruction of the small bowel with a normal colon. Laboratory examination was normal except for a leucocytosis of 14,000, of which 84 per cent were polymorphonuclear cells.

The diagnosis of small bowel obstruction, possibly due to a band, was made, and laparotomy was advised but the patient refused to permit surgery. A Cantor tube was introduced and intravenous feeding was begun. There was no change in the condition of the patient and three days after admission to the hospital she agreed to submit to an operation. This was one week after the onset of her illness.

Under pontocaine-sodium pentothal anesthesia the abdominal cavity was entered through a right paramedian incision. A moderate amount of sero-sanguinous fluid was encountered and an obstruction of the ileum was found about five cm. above the ileo-cecal valve. This was seen to be due to a congenital fold of peritoneum which, extending from the right lateral parietal wall beneath the cecum and crossing the terminal ileum, merged into the upper surface of the ileal mesentery. This four cm. band, which blended in to the serosa of the ileum, was divided to free the bowel. A retro-peritoneal appendix was removed and the abdomen closed without drainage.

The postoperative course was complicated by a central pneumonia which subsided rapidly under appropriate treatment. The patient was discharged from the hospital on her twelfth postoperative day and has enjoyed good health up to the date of this writing over three years later.

DISCUSSION

There are seven distinct types of intraperitoneal accessory membranes or bands.

1. *The Genito-mesenteric Fold.* (Reid's Band). This membrane is a triangulae fold of peritoneum which originates on the back of the terminal mesentery from the junction of the second and third parts of the duodenum to the region of the suspensory ligament of the ovary or testis. It is on the right side and is often closely related to the uterus, right ovary and appendix. It is said to be the cause of binding down and kinking of the appendix. The first case is thought to be an example of this condition.

2. *The Ileal Membrane.* (Lane's Fold.) This extends from the right iliac fossa to the anti-mesenteric border of the terminal five to eight cm. of the ileum. It is a prolongation of the parietal peritoneum of the right iliac fossa. Lane postulated that shortening of this band leads to obstruction of the terminal ileum at the point of fusion of the band. This theory is confirmed by the circumstances related in the second case.

3. *The Pericolic Band.* (Jackson's Veil). This band is commonly found in operation for appendicitis. It is a thin delicate fold of peritoneum which extends from the right posterior parietal wall lateral to the ascending colon to the anterior taenia of the cecum of lower portion of the colon.

4. *The Cholecystoduondenocolic Membrane.* (Cysto - gastro - colic Band). Niles'[0] has suggested the term Harris' Band for this not uncommon anomaly although it was first noticed by Virchow in 1853. It is a variable of development of the hepato-gastric ligament and usually stretches from the under edge of the liver, over the gall bladder across the duodenum (to which it may be fused) to the right transverse colon. Mahoney[8] points out that the wide anatomic variations of this membrane may cause symptoms referable to any of the viscera to which it happens to be attached.

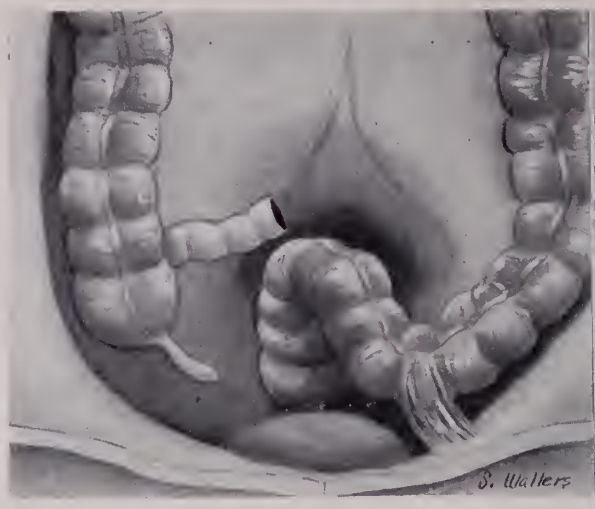


FIGURE 5. *The mesosigmoid membrane.*



FIGURE 6. *The mesocolicojejunal band of Coffey exposed by turning the transverse colon upward.*

5. *The Mesosigmoid Membrane.* (Lane's First-and-Last Kink). This band is the left sided counterpart to Lane's ileal band and is a hypertrophic shortened duplication of the peritoneum of the left iliac fossa binding the sigmoid colon down to the brim of the pelvis. According to McGregor [11] it was the first to appear embryologically and last in the sense that it involves the last or lowermost part of the bowel.

6. *The Mesocolicojejunal Membrane.* (Coffey's Band). This is a rare band of variable width and length extending from the posterior surface of the transverse mesocolon to the antimesenteric border of the jejunum below its point of emergence past the ligament of Treitz.

7. *The Intercolic Membranes.* (Payr's Membranes). These are folds of the colic peritoneum which are sometimes seen extending across the acute angles of the hepatic and splenic flexures of the colon. They are of little or no clinical significance although it was once thought that they contributed to stasis of the fecal flow in the colon.



FIGURE 7. *The intercolic membranes traversing the acute angles of the colic flexures.*

CONCLUSION

There is very little information available in the medical literature regarding the occurrence of congenital intra-abdominal bands. A few scattered reports have called attention to the presence of these dangerous structures but many surgeons are not familiar with the various types of bands which may be present within the scarless abdomen. For this reason the seven clinically recognizable kinds of congenital bands have been described and two cases have been presented to illustrate the presence of potentially lethal congenital bands.

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PANCREATIC CYSTS

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Four patients with a cyst of the pancreas have been studied and treated at this hospital within the past two years. In the previous 10 years no similar cases could be found. It is the purpose of this paper to discuss pancreatic cysts in general, to emphasize the roentgenological signs associated with them, and to present the four cases which stimulated this work.

CLASSIFICATION

The classification used by most writers was originated by Mahorner and Matson[20] in 1931. This was slightly modified in 1946 by Adams and Nishijima[1], and this modification is the one closely followed here.

1. *Retention Cysts* — These unilocular cystic lesions result from obstruction to the outflow of pancreatic secretions by either calculi, tumor or chronic pancreatitis. They are usually lined by epithelium similar to that lining the pancreatic ducts. These cysts are apt to be small and are usually not clinically significant. Actually, the clinical impression that retention cysts result secondary to duct obstruction has practically no experimental background. In laboratory animals one finds fibrosis of the parenchyma, atrophy of the acini, and duct dilatation when the ducts are obstructed. Lazarus, as quoted by Meyer[21], was able to produce a small retention cyst after simultaneously ligating the main duct and injecting tincture of iodine into the substance of the gland. Confirmation of this work could not be found.

2. *Proliferative Cysts*: These lesions are true neoplasms and histologically are either cystadenoma or cystadenocarcinoma. Both lesions are almost always multilocular. There is no associated history of trauma or of biliary disease.

3. *Embryonal Cyst*: These also are neoplastic in origin and histologically are either dermoids or teratomas.

4. *Parasitic Cysts*: The hydatid cyst of the pancreas is rare. Only 40 had been reported up to 1920. The cysticercus cellulosae may produce pancreatic cysts, but these are usually very small, being only seven to 15 mm. in diameter.

5. *Congenital Cysts*: This group includes those due to defective development. The majority are in the recently recognized entity of cystic fibrosis of the pancreas. The cysts are usually multiple and are frequently associated with congenital anomalies of other viscera, especially polycystic lesions in the kidneys.

6. *Pseudocysts*: This group includes (a) those collections of fluid which form within the substance of the pancreas as a result of a hemorrhage, necrosis, and other degenerative changes affecting the parenchyma of the gland, and (b) those collections of fluid which lie adjacent the pancreas and are due to the corrosive pancreatic ferments. These peripancreatic encysted fluid collections lie in the lesser peritoneal cavity. The degenerative cysts which arise within the gland will rupture into the lesser peritoneal cavity when the necrotic process reaches the anterior surface of the pancreas. If the foramen of Winslow is sealed off, the lesser omental sac becomes a closed space and the exudate becomes encapsulated by the proliferation of fibrous connective tissue.

The walls of these pseudocysts are dense connective tissue which will be unusually vascular if the collection of fluid is of relatively recent origin. There is no epithelial lining. This absence of an epithelial lining has been used to differentiate them from true pancreatic cysts of the retention or proliferative types. Differentiation is often impossible since a large retention cyst may have its epithelial lining undergo pressure necrosis, or the proliferative cysts may have their linings destroyed by pancreatic enzymes.

Several factors may account for the origin of pseudocysts. Trauma is undoubtedly an important one. The first result of trauma to the pancreas is hemorrhage. After this comes necrosis and the changes due to liberated pancreatic enzymes. These ferments may so alter the hemorrhagic fluid that it will be clear or straw colored, but it is more often dark brown or brownish green. The fluid may contain particles of sequestrated pancreatic tissue. It is intriguing that the pancreas is the only organ in the body which reacts to trauma by self destruction. Its anatomical position anterior to the vertebral column makes it unusually vulnerable to blunt trauma. Yet the part that trauma plays in pancreatic and peripancreatic accumulations of fluid has probably been ac-



FIG. 1. CASE 1. *There is a general widening of the duodenal loop with pressure on the inferior portions of the pyloric antrum and duodenal cap. The mucosal pattern in the descending duodenum is smoothed.*

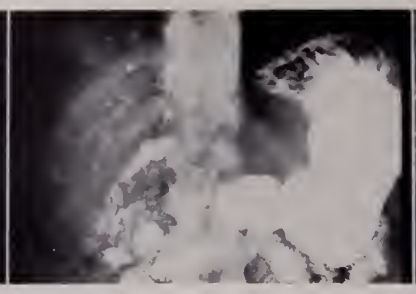


FIG. 2, CASE 1. *Examination done six months after the gastrojejunostomy and choledochojejunostomy. The cyst had been opened, drained and closed. There is no evidence of widening of the duodenal loop. The common duct is moderately dilated, and the liver radicals are well outlined with barium.*



FIG. C, CASE 2. *The body of the stomach is displaced forward and upward and stretched across a large soft tissue mass behind it. The duodenal cap is displaced to the right, and the transverse duodenum is displaced downwards. (Retouch of original film)*

corded undue significance in the early literature.[8,24,25,33] Acute and chronic pancreatitis accounts for many cases of pseudocyst, and some writers think the majority are due to such an origin. It is outside the scope of this discussion to consider the relationship of biliary tract disease to acute pancreatitis. Statistically, however, Pinkham[25] reported 10 cases of pseudocyst, six of which were thought to be secondary to acute pancreatitis and hemorrhagic necrosis. In four of these six there was associated biliary tract disease. Meyer[21] reported 31 cases and found cholecystitis and pancreatitis as the etiological agents in six (16.1 per cent). Adams and Nishijima[1] reported cholelithiasis in two (40 per cent) of their five cases. Judd[17] reported 17 (36 per cent) out of 47 cases had associated biliary tract disease. An additional factor which may produce a pseudocyst of the pancreas was reported by Russ[30] in 1921. His patient developed a cyst during the course of puerperal sepsis, and the possibility of an embolus, either sterile or infected, producing a necrotic area in the pancreas was suggested.

INCIDENCE

Cysts of the pancreas are rare. Adams and Nishijima[1] reported nine cases at the Lahey Clinic between 1926 and 1945. Warren[33] reported seven additional cases from the same institution between 1945 and 1948. Holt[14] was able to find 13 patients with a confirmed diagnosis of pancreatic cyst at the University of Michigan Hospital over an 11 year period. Rabinovitch and Pines[29] reported 17 cases in 1942. Matson and Mahorner[20] reported 88 cases in 1931 from the Mayo Clinic in a total of 723,797 admissions for an incidence of 0.012 per cent. Johnson and Gibson[16] could find only seven pancreatic cysts treated at the University of Kansas Medical Center in a 12 year period between 1936 and 1948.

Of the surgically important lesions, the pseudocysts are statistically much more prominent than any other group. Unfortunately, it is sometimes impossible to distinguish the retention and proliferative cysts from the pseudocyst due to occasional occurrence of necrosis of the epithelium lining the true cysts. This fact may cast some doubt on the accuracy of some of the surveys published. An extensive work on pseudocysts was done recently by Meyer[21] in 1949 when he was able to collect 31 cases of pseudocysts operated upon at Cook County Hospital between 1930 and 1948. Rabinovitch and Pines[29] reported 11 pseudocysts in a group of 17 pancreatic cysts. Waltman and Cleveland[32] reported on 55 cases of pancreatic cyst which had pathologic confirmation and classification. Twenty-four (43.6 per cent) of these were pseudocysts, 13 (23.6 per cent were retention cysts, seven (12.7 per cent) were cystadenomas, and four (7.2 per cent) were cystadenocarcinomas. In Warren's[33] 16 cases, eight (50 per cent) were pseudocysts, two were papillary cystadenomas, four were retention cysts, and one was a hemorrhagic cyst.

Proliferative pancreatic cysts are quite rare. Brunschwig[4] estimated that only about 40 cases of cystadenoma had appeared in the literature up to 1942. Haukohl and Melamed[12] were able to collect 11 additional cases between 1942 and 1950. Bowers, Lord and McSwain[3] in 1942 reported five cases of cystadenoma which comprised all the surgically treated cystadenomas at New York Hospital up to that time. These authors mentioned that four of these five cases had associated biliary tract disease but questioned any pathogenic relationship between the two.

In Johnson and Gibson's[16] seven cases, only one cystadenoma was found.

Pseudocysts occur about equally between the two sexes. The increased incidence of biliary tract disease in the female is probably offset by the increased occurrence of upper abdominal trauma in the male. Cystadenomas are much more common in the female. Haukohl and Melamed[12] found 89 per cent of the recorded cases were in female patients.

The cystic lesions of the pancreas are seen more commonly in the middle age group. They have been found in early life. Telling and Dobson[31] reported a pancreatic cyst in an 11 month old child. Eha[7] reported a congenital cyst of the pancreas without an epithelial lining in a five month old infant. The cases of cystic fibrosis of the pancreas are almost all seen in the first few months of life.

SYMPTOMS

The symptoms due to a pancreatic cyst are dependent upon the precipitating factors, the size and location of the lesion, and the duration of the disease. In many instances there are no subjective complaints since these cysts may be quite slow and insidious in onset. When the cyst is of traumatic origin, this fact is usually prominent in the history. In Meyer's[19] series the time interval between the traumatic incident and the discovery of the pseudocyst averaged five months. There is a triad of symptoms commonly found: Upper abdominal pain, pressure symptoms from adjacent organs, and the presence of a palpable mass.

Pain is the most constant and most important subjective complaint. It varies from a sensation of fullness after meals to sharp abdominal cramps. Its location is usually epigastric, but will often radiate through to the back. The pain, however, is apt to be quite variable in degree. Its location is of little diagnostic value. Weight loss, anorexia, nausea and vomiting are often associated. The occasional occurrence of chronic pancreatitis with a benign pancreatic cyst will add additional symptoms. These patients will have a history of long standing intermittent episodes of abdominal pain associated with the gradual development of an upper abdominal mass.

Diarrhea is seldom encountered. Jaundice may occur when a cyst has grown large enough to obstruct the common bile duct. Pressure on the portal vein may produce ascites. Only rarely does one find foamy stools, but an excess amount of fat in the stools may be a manifestation of pancreatic deficiency. Recently, Gross, Null and Loeb[10] reported a case of hydrothorax associated with pseudocyst of the pancreas. They were able to collect five other such cases from the literature. This has been likened to the formation of hydrothorax with a benign intrapelvic tumor in the female as seen in Meig's syndrome.

The presence of an abdominal mass is sometimes the only complaint. In most of these patients the history is of slow growth over a long period. The mass may enlarge suddenly. A phenomenon which is almost limited to pancreatic cyst is its spontaneous disappearance followed by re-appearance in a few days. According to Hess and Rutte[15] this occurs in about five-10 per cent of the cases. This unique behavior has not been adequately explained, but the most logical explanation is that emptying occurs through the duct of Wirsung when the pressure within the cyst has reached a certain level.

The abdominal mass is smooth to palpation, and often is so firm that fluctuation cannot be demonstrated. When the mass is located in the head of the pancreas, it is relatively fixed, but the tumor may descend slightly upon deep inspiration. When the mass is located in the tail of the pancreas, it may be slightly or even freely movable. Cysts which are of inflammatory origin are likely to be somewhat tender.

Laboratory data may be of some assistance in diagnosis. Pinkham[25] noted an elevated preoperative serum amylase in six patients which dropped promptly after drainage in four. He thought that a sustained elevation of serum amylase after acute pancreatitis suggested the development of a pseudocyst. Meyer[21] had preoperative serum amylase levels in eight patients, and found two of these abnormally elevated. In both cases a ruptured cyst was found at operation. There seems to be a slight increase in the incidence of diabetes in patients with pancreatic cyst. Warren[33] found diabetes in three (18 per cent) of 16 cases. Bowers et al[2] found it in three of five patients and reported postoperative improvement in one. On the other hand, no patient in the 31 cases of Meyer had diabetes. The stools should be examined for free fat, and if duodenal contents are obtained a deficiency of pancreatic ferments may be found.

ROENTGEN MANIFESTATIONS

Cystic lesions of the pancreas cannot oft-

en be visualized directly on the scout films of the abdomen since their density is approximately the same as that of the surrounding tissue. Occasionally, a soft tissue mass can be clearly outlined and rarely there will be calcifications in the walls of the cyst. Haukohl and Melamed[12] reported two cystadenomas with stromal calcification but were unable to find similar reports. Pascucci[23] found only 16 cases of pseudocyst of the pancreas which had an associated pancreatic parenchymal lithiasis. Alexander and Lowder[2] reported two patients who had pancreatic calcifications arranged in a spherical fashion. A cystic change within the pancreas was accurately predicted.

It is unfortunate that there is no excretory method of visualizing the pancreatic ducts. X-ray findings are dependent upon the site of origin of the cyst and its subsequent direction of growth. Diagnosis depends upon indirect evidence obtained by outlining contiguous structures.

Cysts in the head of the pancreas cause a smooth, rounded enlargement or fanning-out of the duodenal loop. This pressure will alter the mesial ends of the duodenal mucosal folds. It must be noted that hypersthenic and obese individuals with high, horizontal stomachs normally present large duodenal loops which may be mistakenly called abnormal widening. The duodenal loop is displaced to the right, often anteriorly, and may show a slight narrowing of the lumen. This diminished diameter of the duodenum may be enough to produce partial obstruction with delayed gastric emptying. The pyloric end of the stomach is usually not deformed or displaced. The transverse colon is displaced downwards and forward.

Cystic lesions arising in the body or the tail of the pancreas displace the body of the stomach forward, and it may be either upwards or downwards. There is usually a concave deformity of the stomach, the concavity being towards the tumor. This defect is located on the lesser curvature of the stomach when the lesion arises from the head or body of the pancreas. The indentation is on the greater curvature of the stomach when the cyst arises in the tail. In the latter situation, it may entirely disappear in the erect position. A tumor extrinsic to the stomach can sometimes be pushed away from the stomach by palpation under the fluoroscope, with alterations of the deformity. The margins of the gastric defect are apt to be fuzzy and indistinct when produced by an extrinsic mass. Also this compression deformity may show a striking change in form when the patient is changed in position. The mid-transverse colon is displaced forwards, and usually downward. There may be compression and partial obstruction. Sometimes the distal transverse duodenum is displaced downwards and in such a case the duodenum proximal to this may be a little dilated. Other signs of significance than those mentioned are alteration of the left psoas shadow and compression of the left ureter causing a partial obstruction. Sometimes the distal transverse duodenum is displaced downwards and in such a case the duodenum proximal to this may be a little dilated. Other signs of less significance than those mentioned are alteration of the left psoas shadow and compression of the left ureter causing a partial obstruction.

SURGICAL MANAGEMENT

There are three methods of attack open to the surgeon confronted with a cyst of the pancreas: (a) Marsupialization, (b) total excision, or (c) internal drainage. Each method has some merit and certain limitations.

Marsupialization or external drainage is the simplest method with the lowest mortality and is the one most commonly used. It seems to be the elective procedure in critically ill patients. It is also the method of choice in the presence of severe degrees of pancreatitis or peripancreatitis where resection of the cyst is impossible or unwise. Unfortunately, marsupialization is sometimes followed by recurrent cyst formation[26,27] or by a persistent external fistula.[21] A persistent fistula may have frequent hemorrhages, may become secondarily infected, or may cause considerable inanition by continual loss of pancreatic juice. The continued drainage of these pancreatic ferments may also cause a painful erosion about the abdominal wall stoma. It has been demonstrated in the past that the fistulas can sometimes be eliminated by chemical irritants, such as sodium morrhuate. External irradiation has been used successfully in a few patients to destroy the epithelial lining of the tract and produce fibrotic closure. A second operation is occasionally done where the fistulous tract is anastomosed to the jejunum. Banthine will inhibit the external secretions of the pancreas and has been used with gratifying results[27] in postoperative fistulas. Warren[33] states that marsupialization should be con-

fined to pseudocysts of the pancreas, and that external drainage should be done before the cyst walls become thick and rigid.

Total excision should be done in all cases where the cyst can be easily enucleated. This requires careful and patient dissection. Retention cysts are the ones most easily extirpated because they have a paucity of inflammatory reaction around them. Ideally, all proliferative cysts should be removed completely because these may undergo malignant degeneration. Gurwitz and Hurwitz[9] feel that non-proliferative cysts in the head of the pancreas should not be extirpated because of the high incidence of injury to the common bile duct and to the pancreatic duct. Kunc[19] warns that complete removal is technically arduous and is apt to be accompanied by profuse hemorrhage. In two European series there was a mortality rate of 10.7 per cent which is said to increase to 55 per cent if the intended extirpation of the cyst proves impractical during the operation. Total excision is usually reserved for the smaller cysts which have few or no adhesions about them. Even then, trauma to the pancreas during surgery may produce an acute pancreatitis or a pancreatic fistula.

Internal drainage is done by anastomosis of the cyst with the stomach, gallbladder, duodenum or jejunum. This has become increasingly popular in recent years. This procedure was first done in 1927 when Hahn[21] anastomosed a cyst to the jejunum. There were early objections to this method since it was felt there was a danger of spilling alimentary tract contents into the cyst cavity producing more necrosis of the pancreas. This, however, has not occurred, apparently because there is no connection between the cysts and the main pancreatic ducts. Cystocholecystostomy seems to be the least desirable since the cyst is prone to empty incompletely, and since there is usually associated biliary tract disease. When internal drainage is done, anastomosis to the jejunum seems preferable with or without utilization of the Roux-Y principle.[22]

Pancreatic cysts should not be aspirated. Such a procedure is futile and dangerous. A chemical peritonitis can easily be produced.

Koucky, Beck and Todd[18] have called attention to cases of pseudocysts which rupture before operation. These authors reported six such cases from Cook County Hospital. The perforative episode was quite similar in all, and closely resembled a patient with a perforated peptic ulcer. These acutely ill patients also resembled those with a ruptured gallbladder. A history of an upper abdominal mass which disappeared with the onset of the symptoms of peritonitis helps in the differential diagnosis. Four of these six patients died.

REPORT OF CASES

Case 1. This 65 year old, white female, first entered the hospital on 11 26/46, complaining of a continuous mild jaundice of four-five months duration. The icteric index varied between 10.6 and 18.5. The cephalin flocculation test was negative. No abdominal masses could be felt, and the liver was not enlarged. The gallbladder failed to concentrate Priodax tablets. The jaundice gradually cleared in a couple of weeks, and she was well for about 15 months. Her second admission was on 2/17/48, with a history of progressive jaundice for one month and an icteric index of 31.7. Laparotomy was done 2 21/48. The gallbladder wall was thickened without stones, and the cystic and common ducts were moderately dilated. A probe could be easily passed from the common duct into the jejunum. The head of the pancreas was enlarged but not hard. The gallbladder was removed, a "T" tube placed in the common duct, and the head of the pancreas biopsied. Microscopically, the gallbladder showed chronic cholecystitis; the pancreas was reported as showing recent hemorrhage due to surgery. Her postoperative course was smooth, and the "T" tube was removed after six weeks.

The third admission was on 10/19 51, with a history of progressive jaundice for two and one-half months. Her icteric index was 149.2. The total serum proteins were 6.6 gms. per cent. A gastro-intestinal series showed some fixation of the distal 3 cm. of the stomach without displacement. The duodenal cap was elongated, and the duodenal loop was moderately widened. A pre-operative diagnosis of tumor of the head of the pancreas was made. Laparotomy was done on 10/23/51. A multiloculated cystic mass 4 x 6 cm. was found in the head of the pancreas which contained a light-greenish colored fluid. This cyst was obstructing the lower end of the common bile duct. A generous biopsy of the pancreatic wall was done. The opening into the cyst was closed after aspiration of the cyst contents. An anterior gastrojejunostomy and a choledochojejunostomy were performed. Due to this patient's poor condition it was not thought advisable to attempt extirpation of the tumor. Amylase content of the cyst fluid was 20 mg.

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Postoperatively she had a stormy course, developing hypokalemia and cystitis. She was markedly improved when discharged 11/17/51. Pathologic diagnosis was benign cystadenoma of the pancreas. She was admitted a fourth time on 12/5/51, with a history of severe vomiting of 36 hours duration which had begun with a chill and a left-sided convulsion. She had weakness of the left arm and leg. All symptoms and signs cleared within 48 hours on parenteral fluids. She was last seen on 4/23/52, and had no complaints. No abdominal mass could be palpated. A gastro-intestinal series done at this time showed no widening of the duodenal loop.

Case 2: This 74 year old, white male, first entered the hospital 10/9/50, with a history of intermittent abdominal pain and distention for a period of two years. A large upper abdominal mass had been noted for about four-five months by the patient and his physician. There had been no weight loss. A gastro-intestinal series showed the fundus of the stomach displaced upwards, the body of the stomach displaced forward, and the pyloric end of the stomach displaced forward and to the right by a large upper abdominal mass posterior to the stomach. There was no delay in emptying of the stomach. The transverse colon was stretched across this abdominal mass, being displaced anteriorly. The preoperative diagnosis was pancreatic cyst. The urine was negative for sugar. Laparotomy was done 10/14/50, and a large mass was found arising from the lesser peritoneal cavity, extending under and through the transverse mesocolon. This mass was a multiloculated cyst containing 4,000 cc. of brownish-green fluid. After aspirating this fluid, the cyst was excised. There was disruption of the abdominal wall on the ninth postoperative day. This was closed and no additional difficulty was encountered. Microscopically, the cyst cavity was lined by a dense hyalinized fibrous tissue without any definite epithelial lining. This was thought to be a retention cyst with necrosis of the lining. This patient has had no additional intestinal symptoms. A transurethral prostatectomy was done 8/16/51, with a normal postoperative recovery.

Case 3. This nine year old, white boy, fell from his bicycle on 4/21/51, striking his upper abdomen against the handlebar. He was admitted to his local hospital about an hour later with a blood pressure of 100/64, a pulse of 120. He was cold, sweaty, and his nail beds were cyanotic. A presumptive diagnosis of ruptured spleen was made. Following transfusions he did so well over the next 10 days that exploration was not thought necessary or advisable. One month after his initial injury he fell from a teeter totter and again was brought to the hospital with a clinical picture similar to that on previous admission. Within 24 hours, he was well again. During the next month a mass in the left upper abdomen appeared and grew gradually. He began having difficulty ingesting solid foods, but there was no vomiting. There was about 10 pounds weight loss in the two months following the original injury.

The patient was first seen at Wesley Hospital on 6/22/51. He was lethargic and seemed chronically ill. A large, firm smooth mass could be easily felt in the left upper abdomen which extended obliquely downwards to the umbilicus. This mass was fixed, and did not move with respiration. It was slightly tender. There was a mild anemia with 3.59 million RBC and 10.5 gm. per cent hemoglobin. Intravenous pyelo-



FIG. 4, CASE 2: *Lateral view of stomach and duodenum. The body of the stomach is displaced forward, and the distal one-third shows the musocal pattern is "ironed-out." The duodenal cap is lying somewhat anteriorly.*

FIG. 5, CASE 2: *The transverse colon is stretched across an ill-defined but definite soft tissue mass in the upper abdomen.*

FIG. 6, CASE 3. *PA projection of stomach and duodenum. The body of the stomach shows considerable extrinsic pressure and is displaced slightly to the right. The distal transverse duodenum and the jejunum at and just beyond the ligament of Treitz are displaced downwards and are narrowed. The duodenum proximally is moderately dilated due to this partial obstruction.*

grams showed essentially normal kidneys. A gastro-intestinal series showed the stomach to be displaced anteriorly and slightly to the right by a large retroperitoneal mass. There was a deformity of the stomach which changed as the patient's position was altered. The transverse duodenum was irregularly narrowed and was displaced downwards. A preoperative diagnosis of pseudocyst of the pancreas was made. At operation on 6/26/51, a large, unilocular cystic mass was entered through the transverse mesocolon. Approximately 1,000 cc. of dark greenish fluid was aspirated. It was impossible to remove the cyst because the walls were not sufficiently developed. For this same reason internal drainage was not thought feasible. The cyst was marsupialized and the cavity packed open. Microscopic examination of a portion of the cyst showed a very vascular fibrous tissue. The amylase content of the cyst fluid was 196 mg. per cent. His postoperative course was smooth. The packs were removed slowly from the cavity over a six weeks' period. On 8/13/51, the cavity measured two by four by four cm. and a sinus tract about 2.5 cm. long led to the anterior abdominal wall. When last seen on 12 28/51, all drainage had cleared, and the patient had no complaints.

Case 4: This patient was a 71 year old white female whose only complaint was that of a feeling of fullness in her left abdomen which she had noticed for a couple of months. There was no nausea, vomiting or weight loss. On examination there was a firm, freely movable, non-tender mass in the left flank which was about the size of a large orange. This mass was easily separated from the left kidney by pyelographic study, and each kidney lumen was normal. The colon was not displaced. There was some extrinsic pressure on the greater curvature side of the stomach, but the wall of the stomach was not involved. The preoperative diagnosis was pancreatic cyst.

Laparotomy was done the eighth of August, 1952. The mass was located in the most lateral portion of the tail of the pancreas and was not adherent to any other intra-abdominal organ. It could be easily delivered through the abdominal incision. The lesion was totally excised without difficulty. The mass measured six by seven by 10 cm. It was nodular but well encapsulated. On cut section it seemed to be a solid tumor, yet presented a very loose stroma which surrounded tiny spaces filled with a firm, almost translucent, gelatinous material. Microscopically, these numerous, small spaces were separated by dense fibrous septa; the spaces were lined by orderly columnar epithelial cells. The diagnosis was benign cystadenoma of the tail of the pancreas. Her postoperative course was uneventful.

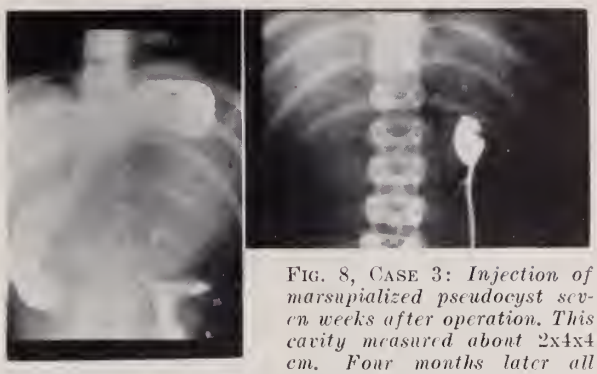


FIG. 8, CASE 3: *Injection of marsupialized pseudocyst seven weeks after operation. This cavity measured about* 2x4x4 *cm. Four months later all drainage had cleared.*

FIG. 7, CASE 3: *AP projection of stomach. Note the considerable difference in the pressure deformity of the stomach when position is changed from PA to AP. The left kidney lumen is still well outlined from previous intravenous urogram. There was no deformity of the kidney. The partial obstruction in the transverse duodenum is again shown.*

SUMMARY

1. Cystic lesions of the pancreas have been discussed according to their classification, incidence, symptomatology, roentgenological findings, and surgical management.

2. Four patients with a cyst of the pancreas have been presented: a cystadenoma of the head of the pancreas which produced obstruction to the common bile duct and jaundice, a retention cyst which was of considerable size, yet was successfully extirpated, a post-traumatic pseudocyst which was marsupialized, and a cystadenoma of the tail of the pancreas which caused only minimal extrinsic pressure changes on the greater curvature of the stomach.

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OBITUARIES

HENRY CLARENCE WEBER, M.D.
1882-1952

Henry C. Weber, M.D., long-time Bartlesville physician, died December 10, 1952.

Doctor Weber was a member of the State Board of Medical Examiners, a past president of the Oklahoma State Medical Association, member of the American College of Surgeons and a trustee of the Oklahoma Blue Cross and Blue Shield. He was a director in the Public Service Company of Oklahoma and a director of the Union National Bank of Bartlesville. He was a trustee in the Bartlesville Lodge 284 A. F. and A. M. and had been a member of the Bartlesville Chamber of Commerce since its organization. He was born in Dempseytown, Pennsylvania February 15, 1882.

Survivors include his widow of the home, one brother and one sister-in-law.

JOHN A. WRENN, M.D.
1908-1952

John A. Wrenn, M.D., Sulphur, died suddenly December 20.

Doctor Wrenn, who had practiced in Sulphur since 1951, was formerly a physician at the Veterans' hospital there and for a short time practiced in Ada. Doctor Wrenn was a graduate of the University of Missouri and the Washington University School of Medicine, St. Louis.

He is survived by his widow, Mrs. Maxine Wrenn, one daughter, and one brother. Burial was at Standsberry, Mo., his former home.

EDWARD D. RODDA, M.D.
1892-1952

E. D. Rodda, M.D., an Okmulgee physician for the past 28 years, died December 18 in a St. Louis hospital following an operation.

A native of Weir, Kansas, Doctor Rodda was a member of the Presbyterian church. He was a veteran of World War I and a member of both the American Legion and the VFW. In 1939 he served as president of the Okmulgee Gun Club and in 1946 he was elected chairman of the board of directors of the Okmulgee Country Club. He was active in all local medical activitoes. In 1931 he studied surgery in Vienna, Austria.

Survivors are his widow of the home, one son, one sister and two brothers.

ROBERT C. TAVLIN, M.D.
1920-1952

Robert C. Tavlin, M.D., Okeene, died suddenly at his home November 30. He had been ill with influenza for several days prior to his death but had recovered enough to resume work at the hospital a few days before his death. Before coming to Okeene in September, 1950, he practiced in Mooreland.

Dctor Tavlin was born in Chicago March 28, 1920. He graduated from the University of Illinois Medical School in 1943 and interned at the Henrotin Hospital in Chicago. He served 26 months as a battalion medical officer in the army and then served a residency at Walther Memorial hospital in Chicago.

Survivors include his widow and four children, his parents, one brother and one sister.

WILLIAM G. McPHERSON, M.D.
1886-1952

William G. McPherson, M.D. died December 13 after a short illness. He had practiced medicine in Oklahoma since 1907. Before coming to Oklahoma City in 1943, where he practiced in Capitol Hill, he practiced at Ardmore.

Doctor McPherson was born at Harmony, Arkansas. He opened his first office in a small community between Wewoka and Holdenville and later practiced at Fort Towson, Healdton, County Line and Wynnewood before going to Ardmore.

Survivors include the widow of the home, two daughters, two brothers, and four sisters.

CLARENCE EDWARD LEE, M.D.
1875-1952

Clarence Edward Lee, M.D., Oklahoma City, died December 6.

The first superintendent of the old Oklahoma County Tuberculosis Hospital, Doctor Lee retired in 1949 and moved to California for a short time.

Doctor Lee was born in Frankfurt, Kentucky April 13, 1875. He was graduated from the University of Kansas Medical School, Kansas City, in 1901. He served with the medical corps in World War I and left the service with the rank of colonel. He was a member of the Methodist church, American Legion, Woodmen of the World, Shrine, Scottish Rite and was active in medical activities.

TINIA CAPITIS DUE TO TRICHOPHYTON SCHOENLEINI (FAVUS)

REPORT OF SIX CASES IN OKLAHOMA

PAUL O. SHACKLEFORD, M.D.
ROBERT J. MORGAN, M.D.
C. JACK YOUNG, M.D.
JOHN H. LAMB, M.D.

The term "favus" refers to a chronic fungus infection of the hairs of the scalp and, less commonly, to other areas of skin caused by *Trichophyton Schoenleini* (*Achorion schoenleini*). Characteristic yellowish, cup-shaped crusts known as scutula are produced on the scalp, with a peculiar mouse odor and frequent evidences of atrophy of the skin.

In reviewing the literature salient points are brought out by almost all of the writers, which we feel to be of interest in discussing this disease: 1) favus[1] does not involute at puberty to differ from the usual fungus infection of the scalp; 2) the disease occurs particularly in the poor and unclean, filth and neglect playing important roles; 3) it most commonly occurs in Poland, Russia, France, Egypt, the Balkans, and country about the Mediterranean basin; 4) it mainly is an anthrophilic rather than zoophilic infestation. Incidence of the disease in the United States is small and reports from the literature reveal scattered locations by states such as New York[2], North Carolina[3], Georgia[4], Kentucky[5], Texas[6], California[7], Missouri[8], and Massachusetts[9]. The total number of cases was relatively small in these reports and the largest number was in the southern states, probably due to immigrant carriers. To our knowledge there have been no previous cases of favus reported in Oklahoma, although our neighboring state of Texas reported two in 1949[6]. Shelmire stated that he had not seen a case of favus in Texas in 20 years. Pipkin[10] cited two of our cases in a recent paper.

These above-mentioned facts, plus the additional fact that our cases (numbering six) have all been seen at the University Hospital in Oklahoma City during the past three years, indicate to us that these should be reported and that we should be cognizant of the clinical features in order to combat this recalcitrant type of tinea capitis. These cas-



RIGHT:

Illustration showing Tinea Capitis due to Trichophyton Schoenleini (Favus)

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es are all from Oklahoma with no foreign extraction or contact with each other. Each family lives in an extreme section of the state from the other patients. The usual fungicides are ineffectual and x-ray epilation is almost mandatory for cure.



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Case	Sex and Age	Duration	Clinical Description	Examination Under Wood's Light	Treatment
No. 1 M.S. Choctaw County	F 8 yrs.	4 yrs.	Numerous manifestations of thick, adherent crusts over scalp. 3 to 4 cup-shaped, bright-yellow mounds of crust. Typical "mouse nest" odor to the scalp.	Dull-gray fluorescense of practically every hair of scalp.	Equal parts of ammoniated mercury and salicylic acid ointment, 10 per cent each. Poor cooperation at home.
No. 2 M.S. Choctaw County	F —6 yrs.	2 yrs.	Multiple, circinate, elevated, crusted, yellowish lesions of scalp with patchy alopecia.	Dull-gray fluorescence of all hairs with glowing of some of the crusts.	X-ray epilation of hairs of scalp using five-point Adems-Kienbock technique. Patient is clear to date.
No. 3 F.S. Choctaw County	M 33 yrs.	Lifetime	Crusting alopecia of posterior half of scalp with typical "mouse nest" odor. No Scutulae noted.	Dull-green fluorescence of each hair of posterior half of scalp.	Equal parts of ammoniated mercury ointment 10 per cent salicylic acid, 10 per cent salnidol ointment. Poor Cooperation.
No. 4 S.M. Jefferson County	F 9 yrs.	1 yr.	Almost complete alopecia with only scattered areas of tufts of hair present. Denuded atrophic areas over the scalp with typical scutulae present and "mouse nest" odor.	Practically every hair revealed a dull, bluish fluorescence.	Boric acid ointment 10 per cent locally; daily shampoos; ammoniated mercury ointment 10 per cent and salicylic acid ointment 10 per cent — equal parts. 20 per cent improvement. Poor cooperation.
No. 5 L.P. LeFlore County	F 18 yrs.	10 yrs.	Scalp contained multiple small, crusted lesions with definite loss of hair. Marked atrophy and cicatrization of the skin at the involved areas. Typical scutulae were present but without "mouse nest" odor.	Dull-gray fluorescence of all hairs of the scalp.	Daily shampoos and instructed how to epilate, using adhesive tape. Unable to get patient to return for any further treatment or observation.
No. 6 M.P. Muskogee County	F 4 yrs.	3½ yrs.	Large, thickened, lesions over scalp with bleeding on removal. Typical scutulae were present with definite "mouse nest" odor.	Dull-green fluorescence of all hairs on scalp.	Furaspor (R) ointment locally; daily shampoos; instructions as to manual epilation of diseased hairs. When last seen (March 1952) patient exhibited 40 per cent to 50 per cent improvement.

LABORATORY

Microscopic examination of the individual hairs in 10 per cent KOH solution in each case revealed large spores in chains with attached hair "bubbles." Long hypheal filaments in the hairs had degenerated and although the outline of them remained, they were replaced by air. Cultures of the hair and scales on Sabouraud's media in each case revealed growth of the causative organism Achorion or *Trichophyton schoenleini.*



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- fenestration procedures
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- radiation sickness

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SEARLE *Research in the Service of Medicine*

President's Page

BUSINESS OR PROFESSION

No matter how you slice it, medicine is a business, but it is hedged in by some factors that set it apart.

In spite of some trite arguments to the contrary, ours is not a private business. For one thing, the tax payers advance many thousands of dollars for our education and if that is not an account receivable in their favor, then I don't know the meaning of decency. Because of our unique advantage, we also have a distinct moral obligation to society in the matter of fees and services. We can't in good conscience proclaim that our practice is a private matter to conduct as we please and charge all the traffic will bear, or to render service when it suits our convenience. In these respects we are definitely circumscribed.

Horse traders are presumably on equal footing, so it is each man for himself and the devil take the hindmost. But this can never be rightly true in medicine.

Patients themselves make it difficult for us to be professional men rather than merchants. "How much will your x-rays cost?" "Are your B.M.R.'s $5.00 or $10.00?", and, "Will there be a special rate on Tuesday?"

After a day in the office where she had received all sorts of tests and studies, a woman demanded an itemized bill, to which I replied that she was charged for only one item, namely, our professional opinion. If I contract for a chicken coop and it is delivered according to specifications, it is of no concern to me what tools the carpenter used in making it. To be sure a job requiring an adze would require more than one that can be done with a grubbing hoe.

We will never recapture the esteem our fathers enjoyed if we allow our vocation to be strictly a business and particularly if we insist that it is entirely a private business run solely for our own advantage.

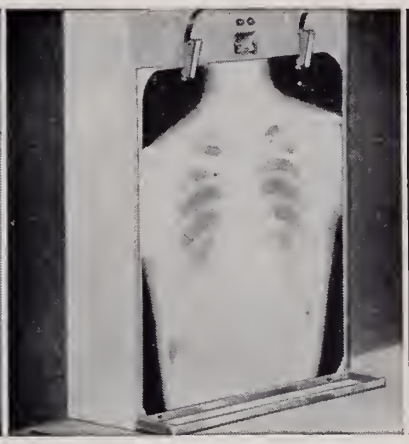
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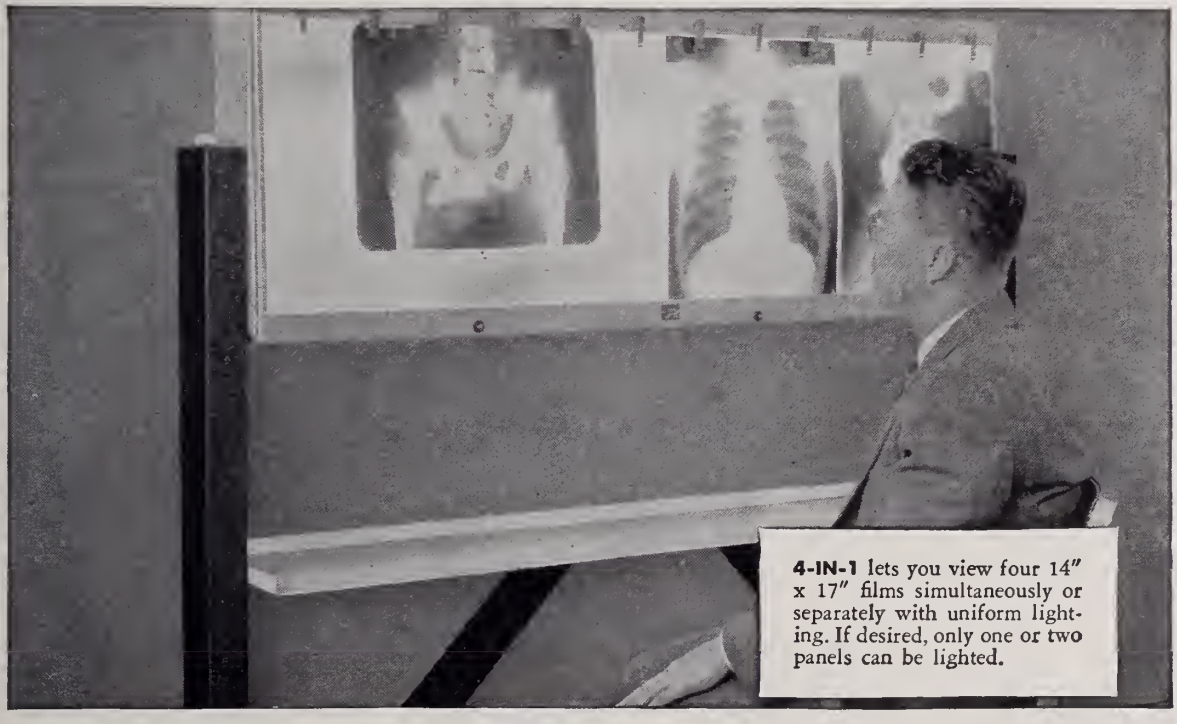
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Oklahoma physicians are invited to attend the fifth annual meeting of the Oklahoma Academy of General Practice to be held at the Biltmore Hotel, Oklahoma City, February 16 and 17, 1953. The two-day meeting will be followed by a symposium on infectious diseases February 18, co-sponsored by the Academy and Lederle Laboratories.

At the time the February Journal went to press, program was still in the tentative stage and was as follows:

Monday, February 16

9:00 a.m. Stewart G. Wolf, M.D., Oklahoma City
"Custom Versus Facts in the Treatment of Peptic Ulcer"

9:30 a.m. Paul Williamson, M.D., Memphis, Tenn.
"Arteriosclerosis"

10:00 a.m. Frank R. Peterson, M.D., Cedar Rapids, Ia.
"Complications and Sequellae Following Cholecystectomy"

10:30 a.m. Break

10:45 a.m. J. Milton Singleton, M.D., Kansas City, Mo.
"The Earlier Diagnosis of Carcinoma of the Cervix"

11:15 a.m. Arild E. Hansen, M.D., Galveston, Texas
"Pertinent Points on the Rheumatic Fever Problem in Childhood"

11:45 a.m. Break

12:15 p.m. *Luncheon and roundtable*

2:00 p.m. *Seminar on family relations*

4:30 p.m. Tour of the Oklahoma Medical Research Foundation

6:30 p.m. Social hour.

7:30 p.m. Dinner and Dancing. Speaker at the dinner will be Mac Cahal, Executive Secretary of the American Academy of General Practice, whose topic will be *"The Public is Your Patient."*

Tuesday, February 17

7:00 a.m. *Breakfast*

9:00 a.m. Louis J. Levy, M.D., Fort Worth, Texas
"Fractured Ankles"

9:30 a.m. Arild E. Hansen, M.D., Galveston, Texas
"Office and Hospital Management of Infantile Diarrhea"

10:00 a.m. Paul Williamson, M.D., Memphis, Tenn.
"The Psychoneurosis, its Diagnosis and Treatment"

10:30 a.m. Break

10:45 a.m. Frank R. Peterson, M.D., Cedar Rapids, Ia.
"Certain Benign Lesions having Malignant Potentialities"

11:15 a.m. J. Milton Singleton, M.D., Kansas City, Mo.
"Diagnostic and Treatment Measures in Sterility"

11:45 a.m. Break

12:15 p.m. *Luncheon and Roundtable*

2:00 p.m. Hugh Payne, Executive Secretary, Oklahoma Medical Research Foundation
"Inside Glimpse into the Oklahoma Medical Research Foundation"

2:30 p.m. Stewart G. Wolf, M.D.
"The Mechanisms Underlying Epigastric Symptoms"

3:00 p.m. Louis J. Levy, M.D., Fort Worth, Texas
"Backache"

3:45 p.m. *Business Meeting*

SCHOOL SLATES OPEN HOUSE TO OBSERVE 60TH ANNIVERSARY

The University of Oklahoma School of Medicine has scheduled an open house for Sunday afternoon, February 8.

"Oklahomans will have an opportunity to see what is being accomplished at the School of Medicine," Dr. Mark R. Everett, dean of the school said. "Conducted tours will be held to enable the public to inspect the building and its facilities."

The open house is part of the week-long celebration held in connection with the University of Oklahoma's Sixtieth anniversary.

One o the highlights of the epen house will be the dedication of the new additions to the Scholo of Medicine building and university officials will be present for the ceremony. Alfred R. Sugg, M.D., Ada, will represent the Oklahoma State Medical Association.

The new additions have doubled the floor space of the School of Medicine building. These additions, which were completed in 1951, include the School of Medicine library, three large air-conditioned classrooms, student laboratories and department facilities.

"With the increased floor space for the scientific laboratories as we'l as the expansion of University hospitals," Dean Everett continued, "the school has been able to educate more students. In the school year of 1950-51 we had 280 medical students. We have 361 medical students this year and will be able to accommodate about 400 students in two more years.

"Of cvourse, the end result of these increased facilities will be more, beter-trained physicians for the communities of Oklahoma in the future," he concluded.

The original structure of the present School of Medicine building, located at Northeast Thirteenth and Phillips Streets in Oklahoma City, will round out a quarter of a century of service this year. Construction started in 1927 and was completed in 1928.

The School of Medicine was established at Norman in 1900. However, only the first two years of a full medical course were offered. In 1910, Epworth Medical College of Oklahoma City was merged with the OU School of Medicine. Under this arrangement, the first two years were taught at Norman and the last two years were taught at Oklahoma City.

Since 1928, the entire four-year curriculum has been offered on the Oklahoma City campus.

ANNOUNCEMENT TO PHYSICIANS OF OKLAHOMA

As Part of Its Program of Post-Graduate Medical Education,
The Oklahoma Academy of General Practice, in Conjunction with
Lederle Laboratories, Takes Pleasure in Inviting Oklahoma Physicians
To a Symposium on ACUTE INFECTIOUS DISEASES at

The Biltmore Hotel, Oklahoma City
Wednesday, February 18, 1953

Medical Sessions—10 am - 12:30 pm
2 pm - 5 pm

Papers will be presented on Mumps, Poliomyelitis,
Infections of the Urinary Tract, Infectious Mononucleosis,
Rabies, Pertussis, Measles, and Atypical Pneumonia

Luncheon and Dinner Will Be Served

Wives of Physicians are Cordially Invited to the Social Functions

There Will Be No Registration Fee

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March 16, 17, 18, 19, 1953

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LOUIS H. CLERF, M.D., Laryngology, Philadelphia

RICHARD V. EBERT, M.D., Internal Medicine, Minneapolis

O. SPURGEON ENGLISH, M.D., Psychiatry, Philadelphia

RICHARD H. FREYBERG, M.D., Internal Medicine, New York City

ROSS GOLDEN, M.D., Radiology, New York City

FRANK H. LAHEY, M.D., Surgery, Boston

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PAUL A. O'LEARY, M.D., Dermatology, Rochester, Minnesota

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433 Medical Arts Building
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HOTEL RESERVATIONS URGED FOR 60th ANNUAL MEETING IN APRIL

Program plans for the 60th Annual Meeting of the Oklahoma State Medical Association in Tulsa, April 13-15, 1953, were nearing completion last month as Dr. Gifford H. Henry, General Chairman, urged Oklahoma doctors to write at once for hotel accomodations.

Pointing to an outstanding scientific program highlighted by the appearance of 10 nationally known medical personalities as visiting distinguished guest speakers, Doctor Henry suggested that members planning to attend use the special reservation card included in this issue of *The Journal* to make reservations.

All requests for hotel accommodations will be handled through the Hotels Committee of the Tulsa County Medical Society in cooperation with the Tulsa Chamber of Commerce. Doctors may save time by writing directly to the Committee as requests sent to hotels will be referred to the Committee for disposition. Please state a first and second choice of hotels, dates of arrival and departure, and type of accommodations desired.

Dr. Rayburne W. Goen, Chairman of the Hotels Committee, said desirable accommodations are available at all major Tulsa Hotels. The meeting is to be at the Cimarron Ballroom. Hotel headquarters will be at The Mayo, where the House of Delegates will meet on Sunday, April 12, 1953. General sessions open on Monday, April 13th, and continue for three days. The Mayo and Adams hotels are located within one block of the Cimarron Ballroom. Other hotels are within walking distance.

Guest speakers for the 60th Annual Meeting will include:

Dr. W. Alton Ochsner, Professor and Chairman of the Department of Surgery, Tulane University School of Medicine, New Orleans, La.

Dr. F. Bayard Carter, Professor and Chairman of the Department of Obstetrics and Gynecology, Duke University School of Medicine, Durham, N.C.

Dr. Garfield G. Duncan, Professor of Medicine, Jefferson Medical School, Philadelphia, Pa.

Dr. Paul H. Holinger, Associate Professor of Otolaryngology, Northwestern University School of Medicine, Chicago, Ill.

Dr. Allan P. Bloxsom, formerly Professor and Chairman of the Department of Pediatrics, Baylor Medical College, Houston, Texas.

Dr. Carl A. Moyer, Professor of Surgery, Washington University School of Medicine, St. Louis, Mo.

Dr. James C. Sargent, Professor and Head of the Department of Urology, Marquette University School of Medicine, Milwaukee, Wis.

Dr. Francis J. Braceland, Professor of Psychiatry, Yale University School of Medicine, and Psychiatrist-In-Chief, The Institute of Living, Hartford, Conn.

Dr. Wendell G. Scott, Associate Professor of Radiology, Washington University School of Medicine, St. Louis, Missouri.

One other speaker will be announced later.

Complete ticket information concerning the President's Annual Dinner Dance will be announced in the March issue of *The Journal*. Featuring the nationally known music of Ralph Flanagan and His Orchestra, the Dinner Dance is expected to attract a capacity attendance. There will be an advance ticket sale.

MEDICAL SOCIETIES AROUND THE STATE

Atoka-Bryan-Coal

At the annual election of officers, LeRoy Engles, M.D., Durant, was elected president of the Atoka-Bryan-Coal Society. He succeeds Charles S. Moore, M.D. R. L. Cochran, M.D., Caddo, was elected vice-president and Seals L. Whitely, M.D., Durant, was named secretary-treasurer.

Oklahoma

Walter H. Dersch, M.D., Oklahoma City, is the 1953 president of the Oklahoma County Medical Society. New officers are Henry G. Bennett, M.D., president-elect; Lewis Carroll Taylor, M.D., vice-president; and Bert Mulvey, M.D., secretary-treasurer. Outgoing president is Ralph A. Smith, M.D.

East Central

Robert H. Furman, M.D., head of clinical research in cardiology at the Oklahoma Medical Research Foundation, was guest speaker at a recent meeting of the East Central Oklahoma Medical Society held at the Severs Hotel in Muskogee.

Creek

D. L. McAllister, M.D., Bristow, was elected 1953 president of the Creek County Medical Society. Other officers elected are Philip Joseph, M.D., Sapulpa, vice-president; and Charles Kent, M.D., secretary-treasurer. Guest speaker at the meeting was Allen Greer, M.D., Oklahoma City.

Grady

Succeeding Wesley W. Davis, M.D., Chickasha, Richard G. Stoll, M.D., Chickasha, was named 1953 president of the Grady County Medical Society. Other officers, all from Chickasha, are H. H. Macumber, M.D., vice-president; and Charles W. Ohl, secretary-treasurer.

Beckham

O. C. Standifer, M.D., Elk City, was elected president of the Beckham County Medical Society for 1953. M. J. Sugarman, M.D., Elk City, is vice-president and James W. Parker, M.D., also of Elk City, is secretary-treasurer. At the meeting for election of officers, the scientific program was presented by Richard Burgtorf, M.D., Shattuck, who spoke on "Fractures of the Upper Extremities."

Garfield-Kingfisher

Hope Ross, M.D., Enid, was elected 1953 president of the Garfield-Kingfisher County Society to succeed B. J. Cordonnier, M.D., also of Enid. John R. Taylor, M.D., Kingfisher, was elected vice-president and Roscoe C. Baker, M.D., Enid, was re-elected secretary-treasurer.

Cleveland-McClain

Charles A. Smith, M.D., superintendent of Central State Hospital, Norman, is the new president of the Cleveland-McClain County Society. Other officers are Kirk T. Mosley, M.D., vice-president; and Jim Haddock, secretary-treasurer.

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CURRENT ACTIVITIES AT THE OKLAHOMA MEDICAL RESEARCH FOUNDATION

EDWARD C. REIFENSTEIN, JR., M.D.
DIRECTOR



This is the fifteenth in the series of monthly articles concerning the current activities of the Oklahoma Medical Research Foundation. This article describes the investigative program in the field of cardiovascular disorders. The work of the Cardiovascular Section is supported by funds from the Oklahoma Medical Research Foundation, the Oklahoma State Heart Association, the Noble Heart Fuud, and the National Heart Institute. The latter grant in the amount of $14,000.00 (December 1952-November 1953) was awarded recently.

The Cardiovascular Section was activated when Dr. Robert H. Furman, formerly Assistant Professor of Medicine, Nashville, Tenuessee, assumed his duties as head of the Sectiou on April 1, 1952 (see *J. Okla. State Med. Assoc. 45:30,* Jan. 1952). In July, 1952, Dr. Loyal Lee Conrad, formerly Chief of the Oklahoma University Hospital Clinical Pathology Laboratories, became associated with Doctor Furman in the Cardiovascular Section (*see J. Okla. State Med. Assoc. 45:430,* Dec. 1952).

While much of the effort to date has been concerned with acquiring ancillary personnel aud developing techniques and instrumentation, actual research work has been under way since July 1952. Most of this has beeu in the field of atherosclerosis.

Search has been made for a simple method for the quantitation of "clearing factors" or "antilipemia substances" which appear related to, if not necessary for, the stable and orderly transport of serum lipids. It is postulated that aberrations in the clearing or antilipemic properties of plasma may be related to atherogenesis. Preliminary studies indicate that various stable emulsions prepared by the use of high pressure viscolizers may be utilized to demonstrate the clearing property of plasma. Clearing is measured by changes in the optical density of the emulsion. The pH of plasma is being measured to determine whether or not clearing is associated with the release of fatty acids, and plasma has been tested from fasting subjects before and following the injection of heparin. In addition, studies utilizing paper and/or zone electrophoresis techniques are planned in an effort to determine whether or not changes in the electrophoretic patteru of plasma proteins can be related to changes in the clearing properties. A significant deviation from the "normal" has been noted in a group of diabetic subjects.

Preparative, analytical and ultracentrifuges are scheduled for arrival at the Oklahoma Medical Research Foundation in December, 1952, or January, 1953, and, when these instruments have been calibrated and sufficient technical experience has been gained by the operators, an attempt will be made to determine whether or not there exists any correlation between antilipemia factor or factors and the lipoprotein pattern of the plasma. The practical application of these studies will be to provide a partial answer to the following questions:

1) Can plasma emulsifying and stabilizing agents be simply quantitated?

2) Is there any correlation between such emulsifying and stabilizing agents and the presence or absence of abnormal lipoproteins?

3) Is there any correlation between the presence or absence of these agents and atherosclerosis?

4) What are these stabilizing agents?

5) Can they be separated from plasma?

6) Can they be made available for therapeutic use?

In addition to these studies, various therapeutic regimens will be evaluated, including the use of steroid compounds, lipotropic substances, metabolically active hormones and dietary regulation on the lipoprotein pattern and antilipemic activity of plasma from human subjects. The ultracentrifuge, paper electrophoresis and optical density measurements will be utilized in this iuvestigatiou.

Studies in experimental atherogenesis in dogs have been under way for several months, with some very interesting results. A toxic amine substance, known to cause necrotizing arterial lesions when given in sufficient quantity, when administered in small amounts produces two types of lesions, one a proliferation of the intimal cells, and the second a ground-substance lesion resembling that seen by certain observers early in human atherosclerosis. This experimental lesion will be used to assay the value of various substances as prophylactic agents against the development of athersclerosis. Clinical application of such agents is the practical goal of these studies.

A second major field of endeavor concerns cardiovascular and pulmouary dynamics. Initial studies in patients with pulmonary emphysema have indicated that in selected cases the use of artificial pneumoperitoneum has a physiological basis and a therapeutic value. Since the basic pulmonary lesion in pulmonary emphysema is over-distention of the lugs, a project is planned in which partial, controlled pneumothorax will be used iu addition to pneumoperitoneum in order to reduce the volume of the lungs. Such cardiopulmonary dynamic studies will utilize cardiac catherterization, lung volume and ventilatory function measurements. The tooling-up for this investigation has been long and expensive, but the initial phases of this study have been completed, and definitive work will be started on delivery of direct-writing, recording galvanometers, expected shortly. The problem of pulmonary emphysema is unusually important because to date therapeutic measures have been largely ineffective, aud because ever increasing numbers of individuals are entering the "old age group" and developing this disorder.

A relatively new application of the cardiac catheter is planned. This involves the use of radio-opaque plastic catheters, placed intra-arterially, through which the body organs in situ can be perfused. Collaborative studies are planned with the members of the Endocrinology and Metabolism, Biochemical and Cancer Sections of the Research Institute. By this intra-arterial technique certain therapeutic agents such as nitrogen mustard, triethylenemelamine, and aminopterin may be injected directly into organs with various neoplastic diseases.

An experimental therapeutic approach to pulmonary embolism has been devised and is now being considered

(Continued on Page 52)



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HAVE YOU HEARD?

Alfred R. Sugg, M.D., Oklahoma State Medical Association President from Ada, was named to the Board of Directors of the Oklahoma Public Expenditures Council December 11.

D. D. Cramblett, M.D., formerly of Stigler, has recently moved to Holdenville.

Ray J. Camp, M.D., formerly of Woodward, is taking a three year surgical residency in Minneapolis.

J. T. Colwick, M.D., Durant, recently took a postgraduate course in geueral surgery in Dallas.

Frank E. Flack, M.D., Woodward, has opened his offiices at 1218 Eighth St., Woodward.

Roger Reid, M.D., Ardmore, has been elected president of the staff of Hardy Sanitarium there.

L. B. Word, M.D., Bartlesville, was guest speaker at a DeMolay meeting in that city recently. His topic was "Sex."

M. Wilson Mahone, M.D., Hobart, has been named part-time medical consultant for the Kiowa county health department.

J. M. Newton, M.D., formerly of Massachusetts, has beeu named medical director for the Oklahoma State hospital at Clinton.

John B. Jacob, M.D., formerly of Waurika, has been recalled to active duty with the navy. He reported to Memphis, Tenn.

Henry Laurens, Jr., M.D., Ada, has been notified of his election to the American Gastroscopic Society.

M. H. Newman, M.D., Shattuck, has been appointed to the Board of Medical Examiners to succeed his father, O. C. Newman, M.D., who resigned, for the unexpired term.

R. M. Howard, M.D., Oklahoma City, has been selected as the Oklahoma physician to be sent to the World Medical Association first western hemisphere conference in Richmond, Va. in April by the A. H. Robins Co. with all expenses paid.

CURRENT ACTIVITIES

(Contiuued on Page 50)

for financial support by a national organization. Radiographic and fluoroscopic equipment is needed to implement this study, but once this equipment is available the project can be initiated promptly and should reveal definitive results in a very short period of time. If the proposed technique proves feasible it may alter markedly the current method of managing pulmonary embolism. This interesting project will be discussed more fully at another time.

In addition to the investigations outlined above, certain ancillary studies with other Sections of the Foundation are planned. The members of the Cardiovascular Section are responsible also for the cardiac catheterization of patients on the medical service of the University Hospital. In addition to these duties, the professional members of this Section have teaching responsibilities at both the medical student and postgraduate levels. These duties directly related to the program of the Medical School and the University Hospital involve over 20 per cent of the average working time of the members of the Cardiovascular Section.

HISTORY OF MEDICINE COMMITTEE TO MEET

Plans are being made for a meeting of those interested in the history of medicine in Oklahoma. The original meeting of the group was scheduled for January 25 but was postponed because of inclement weather. Physicians from each of the counties were invited to be present along with representatives of the Department of Archives at the University of Oklahoma, the President of the University, Dean of the Medical School, and others. This meeting was to initiate the activities that had been approved by the House of Delegates at its last meeting. Each county society and individual member is urged to cooperate and those interested are asked to contact the Executive Office before the next meeting of the group which will be held sometime following the celebration of the 60th Anniversary activities at the University of Oklahoma, Norman.

Physicians with interesting historical documents, etc. are especially asked to notify the Executive Office or Lewis J. Moorman, M.D., chairman of the History of Medicine Committee of the Association.

DIABETES GROUP TO MEET

Oklahoma physicians are urged to attend a meeting of the Oklahoma State Diabetes Association February 15, 1953 at the Biltmore Hotel at 6:00 p.m. A charge of $5.00 per persou will be made and will include the social hour, dinner and address by Stewart Wolf, M.D., Professor of Medicine at the University of Oklahoma School of Medicine. Doctor Wolf's topic will be "Life Stress and the Diabetic Metabolism."

Reservations may be made through Dr. R. Palmer Howard at the Oklahoma Medical Research Foundation, 825 N.E. 13th St., Oklahoma City, Okla. Reservations, accompanied by a check in the amouut of $5.00, should be made by February 14. Hugh Jeter, M.D., Oklahoma City, is president of the group.

CLASSIFIED ADS

DOCTOR WANTED: Northwest Oklahoma. About 2,500 population to draw from. Nearest medical doctor or hospital 22 miles. Write Key V, care of the Journal.

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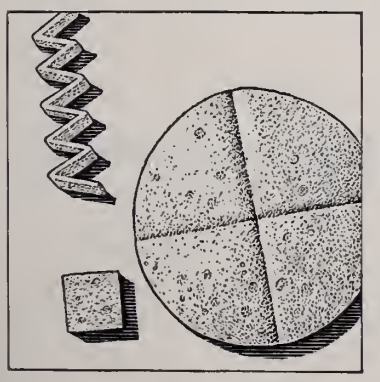
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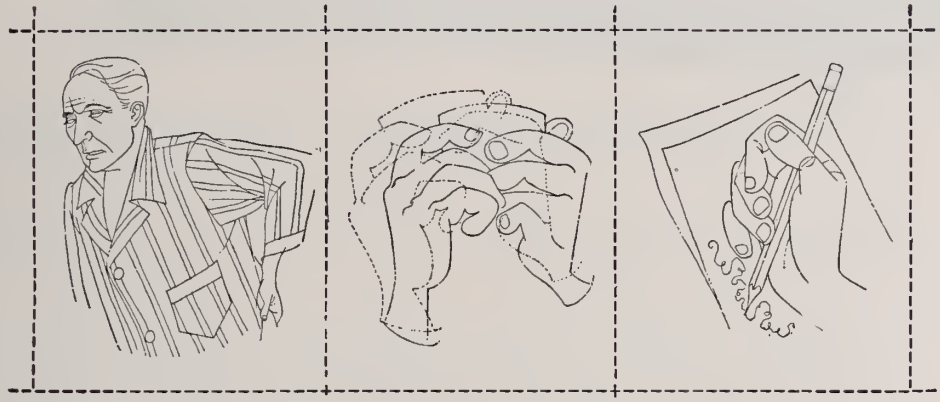
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THE JOURNAL
of the
OKLAHOMA STATE MEDICAL ASSOCIATION

EDITORIALS

THESE DOCTORS RUN A LIBRARY

In *Medical Economics*, February, 1953, Jack Spears, Executive Secretary of the Tulsa County Medical Society, tells how it is done.

This is neither a fairy nor a fabulous story, yet it is a story well worth telling and one that should make the members of all county medical societies sit up and take notice.

The Tulsa County Society is to be commended for this forthright demonstration of what can be accomplished with an ambitious, wide awake, progressive membership.

The well written definitive story is recommended to the officers and governing bodies of all county societies. It will be readily available in the widely distributed Journal of *Medical Economics*.

There has never been a time when physicians were so in need of wide reading. They must never fail to hold a high place in the field of general knowledge as well as in the science of medicine. This is impossible without books and current periodicals.

THE ANNUAL MEETING

The New Year's resolutions should have contained a determination to attend the Tulsa Meeting of the State Medical Association April 13-14-15, 1953. It is not too late to make the Annual Meeting one of your 1953 obligations. The scientific work committee promises a good program. Public relations and political problems continue to command time and attention. This should be a significant season for organized medicine. The members of the State Association cannot afford to miss this meeting. Please circle the date, make hotel reservations and find time for this important event.

THE INCUBUS OF STATE MEDICINE

If we do not curb our cowardice and preserve the rightful privileges of patient and physician, some sad day we will stand face to face with the accusing ghost of our great profession and hang our heads in shame.

WHAT OF THE PHYSICIAN'S FEE

In this materialistic age where realism defies idealism, it may be well for physicians to give serious consideration to these questions.

What physician can fix a standard professional fee. It is an impossibility. Professions are for service, not for profit. Often the physician's fee is in his head, sometimes it is in his heart, occasionally it is in his hand. Every physician should weigh these three possibilities in his conscience before presenting his bill. They should be weighed and processed to meet the individual patient's psycho-socio-economic needs. Regardless of material ends, the prized patient-physician relationship should be preserved. In the final analysis, this is the only way to make the practice of medicine truly profitable.

For the genuine disciple of the Father of Medicine, fate often fixes the charge and sometimes an unseen providence takes care of the fee. In some cases payment is prompt and adequate, in some it may be full measure running over, in others the only compensation may be an expression of obvious gratitude, a "God bless you" or "I never forget to remember you in my prayers." The physician who spurns such expressions of faith and good will is short sighted, undeserving of reward. The possibility of long range returns, though not anticipated, should be kept in mind. They may be surprising, not inconsequential. Recently a surgeon over a period of years estimated referred work from a patient who was unable to pay for her own operation as amounting to approximately $30,000. Though the poor are always with us, so are their relatives and friends, many of whom are able to pay. The washer-woman across the track with the rich folks' washing on her back may be able to deliver the services of her physician with the clothes. Faith, hope and charity are always worth the money, and because of hidden values, the greatest of these is charity.

MEDICINE FOR THE PEOPLE, NOT BY THE PEOPLE

From the days of Hippocrates, medicine has pursued its evolutionary course. It has consecutively found its way through the rise and fall of nations and governments. In its course, it has unraveled the secrets of nature and gradually revealed the cause and cure of disease. The accumulation of knowledge in the care of the sick and the resulting sense of humanism led to comprehensive preventive measures including sanitary engineering and the development of public health.

All this has come through the progress of medical science. The meticulous devotion of the medical profession to its own special field of endeavor in the U. S. has fostered health and happiness, doubled longevity and freed the people to follow their varied pursuits in confidence. In the last analysis it may be said that these results have been achieved in behalf of the people.

Rudely disregarding medicine's overall contributions to the nation's welfare the presumptious New Deal assumes control, disturbing our trust in established principles discrediting our competency, questioning our integrity, overriding the Bill of Rights and cracking the Constitution. The crafty bureaucrats on the road to Stateism quickly fell upon medicine and because of its sympathetic appeal they made it their leading slogan. They argued that medicine must be taken away from a decadent profession and given to the people.

While the medical profession in this age of phenomenal scientific progress continued to move toward greater human weal, the Federal Security Agent and the omnipotent President of the United States took a quick look, made inaccurate statistical surveys under false claims ignoring medical knowledge and historical facts, went to the people with the problem of medical care. Of course, many of the people driven by the problems of existence under an exacting bureaucracy were glad of an easy way. They did not know, neither did the bureaucrats know, that Sophocles more than two thousand years ago because of death and destruction declared that ". . . of all the curses which cleave to man, ill council is the sovereign curse." Under a new administration it may yet be possible to spare the people and leave the penalties to the guilty councilor.

But it must not be forgotten that hanging over the people, the new administration and the medical profession, is the report of the Truman Commission. After making all reasonable allowances, it is difficult to understand how the spokesman for the Commission could say, "we feel that our function . . . is to do everything in our power to bring the basic information contained in our studies to the attention of the American people. Then it is up to them to act upon that information."

Generosity prompts the thought that perhaps the physicians on the Commission had never had an opportunity to learn the needs of the people through house to house calls, but it does not explain why this spokesman refers the problems of medical care to the people instead of the physicians who for the benefit of the people have brought it to its present high point of efficiency. Certainly the people have a vital interest in medical care but they do not know what it should consist of or how it should be administered. May the shades of Sophocles and all the past medical benefactors shadow the issue and save the people and the profession from this unfortunate and no doubt unintentional bit of ill council.

"I DON'T WANT TO GO HOME IN THE DARK"

Often I have said if you will find a good old fashioned family I will endeavor to produce the lamented good old fashioned family doctor.

Though people have strayed from the family circle and deserted the meeting house for the sins of the cinema, they still cling to one old fashioned habit—the habit of dying. In this day of modern medicine, nurses play an important part in the last act and patients are taught not to look for the light of the doctor's presence as the end approaches. In all probability he will get the news over the telephone. Fortunately, most people are as unaware of death as they were of the birth that gave them the privilege of life.

But there was a time when dying people in their lucid moments looked for the doctor and were conscious of his presence, often reached for his hand with a strange light in their eyes. In those days medicine meant friendship, sympathy, and "a help in the time of need."

Dying at dawn, O. Henry said to his doctor, "Turn up the lights, I don't want to go

home in the dark." It must have meant much to this lonely teller of stories about common people to have his doctor light him home. While we are trying to find our own way over strange new roads, would it not be wise to restore this bedside service. People still measure interest by deeds.

TUBERCULOSIS AND THE GENERAL PRACTITIONER

What could be more important in the life of the ambitious, conscientious, general practitioner than a thorough knowledge of tuberculosis? Though it gradually gravitates to a lower position of mortality rating in statistical columns, it still stands as one of most important of all diseases demanding the attention of the General Practitioner. How about combining an interesting and profitable postgraduate course and a pleasant vacation at Saranac Lake in the beautiful Adirondacks. This symposium on tuberculosis for the general practitioner is sponsored by the Saranac Lake Medical Society and the Adirondack Counties Chapter of the New York State Academy of General Practice. The dates are July 13-17.

YOU'RE IN THE ARMY NOW

In World War I it didn't matter about your know how. One of the most skillful surgeons I ever knew marched back and forth in the mud on guard duty in France. During the whole time he never experienced a flash of a scalpel over a scrubbed abdomen. Instead, from exposure he developed a bronchiectasis to dog his lengthening years.

Though our men in Korea have the best army medical care in history, there are echoes of misplaced skills in the service. It is said that the boy who grew up with mules and requests an assignment to the stables is likely to wind up caring for canaries and white mice. A sergeant[1] giving advice to a young recruit said, "Keep your mouth shut and your bowels open, and don't never volunteer for nothing."

1. Keyes, Francis Parkinson. Steamboat Gothic. Julian Messner, Inc., New York. 1952.

A SHORT CUT TO PUBLIC RELATIONS

The shortest road to public relations runs straight through personal relations. Personal relations, good or bad, are dependent upon personality. Personality is a combination of innate psychological traits and individual biological endowments. Through environment and discipline, personality is capable of growth and development. Goethe considered it the "greatest fortune of mortal man." When properly employed, it is the physician's greatest asset.

Unfortunately, the phenomenal progress in medical science tends to push personality out of the picture. The exacting demands of medical education and the exigencies of practice, including the necessity of keeping up with medical progress, leave little time for humanistic pursuits and the deliberate unfolding of personality. Haste limits the time devoted to the patient-physician relationship and whether obvious to the patient or not, diminishes the scope and power of personality and often leaves the patient in a state of uncertainty and frustration.

Physicians should never forget that through the simple art of human kindness and personal effort, they can establish a relationship that engenders interest, good will, esteem, and often genuine affection. Such a relationship between the patient and the physician is well worth striving for and one that brooks no interference. Once this becomes the physician's goal, committees on public relations will go out of business.

A MEMORABLE CAREER

In this issue of the *Journal* our readers will find the obituary of David Wilson Griffin, M.D., and a resolution by the faculty of the University of Oklahoma School of Medicine concerning his services to humanity through many intellectual and professional channels.

Through exceptional courage, foresight, industry, professional attainments and executive ability controlled by a fine sense of integrity and humility he made a contribution to medical progress in Oklahoma.

With these tributes to a great man whose influence carries on, we go to press with bowed heads.

PLAN TO ATTEND

THE O.S.M.A.

60TH ANNUAL MEETING

TULSA, OKLAHOMA

APRIL 13-14-15

House of Delegates April 12

Scientific Articles

EMPHYSEMA

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There are various types of emphysema and different classifications, but the one considered in this paper will be the chronic emphysema which is seen usually in the older patient, mostly males. It is a condition which has been recognized for years, and possibly first described in 1698 by Floyer of Litchfield, who spoke of the disease as flatulent asthma, meaning a condition in which the lungs were blown up by air. The pathogenesis of emphysema is still a matter of speculation. In former years many papers have been written by eminent physicians dealing with various theories as to its origin.

Jenner wrote a paper mentioning increased pressure during expiration as a causative factor. Heightened pressure during inspiration was advanced by Laennec. Some 50 years ago Freund advanced the theory, according to Osler, that it was primarily a disease of the costal cartilages; a chronic hyperplasia with premature ossification was believed to bring about gradually a state of rigid dilatation of the chest to which the emphysema was secondary. Such changes are occasionally seen occurring in young persons, particularly the contraction of the first three ribs; later would come the changes in the spine and shape of the thoracic cage. As a correction for the early rib changes, an operation known as Freund's resection was attempted at that time.

Osler mentions occupations as a cause, stating that the condition was more common in players of wind instruments, in glass blowers, and in occupations necessitating heavy lifting or straining. He also thought that whooping-cough, bronchitis and asthma were important causes.

In "Diseases of the Chest" February 1952, Mayer and Rappaport[1] advance what they consider is a new concept in the medical history of cystic lungs, bronchiectasis and emphysema. The origin of these conditions is traced to postnatal developmental defects. It is their opinion that developmental defects come from defective opening of the lung buds at birth and shortly thereafter. This might be caused by changes in the metabolic process and babyhood diseases, such as whooping-cough, asthma, or other allergic conditions.

It seems likely that all of these theories have a bearing on emphysema as seen in the older patient. The increased expiratory pressure caused by a chronic cough from whatever cause, accompanied by secretion obstructing the bronchioles, could lead to overdistention of the air sacs, lobules and smaller bronchioles. Overdistention of individual sacs means enlargement of the lung with a thinning of the alveolar wall. Coughing with an obstructed bronchiole would increase the pressure causing further distention, which could lead to a rupture of the lobule and a loss of lung elasticity. With the loss of elasticity and a thinning of the lobule wall there would be a diminished elastic recoil and an overdistention of the lung with an increase

in all diameters of the chest. This causes a disturbance in the physiology of respiration. There is a diminished vital capacity. The residual air is increased with the expiratory lung volume being increased. This means a poorer emptying out of the carbon dioxide in expiration leading to a higher alveolar CO_2 tension and a lower alveolar oxygen, which results in poor oxygen absorption by the blood and an increase in plasma carbon dioxide and diminished oxygen saturation. The increased CO_2 further increases the plasma sodium bicarbonate and diminishes plasma chloride, causing a change in body physiology to maintain the proper Ph concentration. The poor oxygen saturation causes increased cardiac output, throwing a burden on the heart, and can later lead to decompensation and also an increase in the red cells, leading to or toward polycythema, and in an advanced degree to a cyanotic coloring of the skin and clubbing of fingers and toes[2].

The symptoms of emphysema usually begin with shortness of breath on exertion. This can continue for months until an acute respiratory infection causes further obstruction of the bronchioles leading to an attack characterized by extreme shortness of breath, cough, weakness, anorexia and debility. As the condition progresses the patient becomes incapacitated as far as work is concerned, so that in extreme cases even slight exertion is an effort.

The physical signs are well known. Inspection shows the diameters of the chest to be increased with the characteristic barrel shape. The dorsal area of the spine shows forward bowing, the ribs are turned upward and outward, with the thoracic cage more or less rigid; the subcostal angle is markedly widened. The X-ray picture as a general thing shows a small heart hanging in the midline, and the domes of the diaphragm to be almost flat; areation of the lung fields is increased and bronchial markings are more prominent. The lateral view shows an increase in the AP diameter associated with an increased retro sternal space and a prominent sternal angle. On respiration the lung fields do not light up in their usual fashion.

The percussion note is hyperresonant and this hyperresonance extends very low at the base of the lung, with little change between inspiration and expiration. On deep inspiration the subcostal border moves inward instead of outward and the thoracic cage is lifted up as a whole rather than being enlarged by the external rotation of the ribs. The breath sounds are altered, usually with expiration being prolonged and wheezing. The heart sounds are frequently distant, and in extreme cases the border of the heart cannot be percussed. As mentioned before, the nails may show cyanosis and clubbing of the finger may be present.

In the differential diagnosis one must determine whether this condition is emphysema, asthma, silicosis, or a form of heart failure. A careful history of slowly progressing shortness of breath on exertion over a period of weeks or months indicates emphysema. The careful history will rule out asthma with its acute attacks of cough and wheezing. Also very frequently the family history of asthma or hay fever is helpful. Anthracosis or silicosis is found nearly always in miners, but this is now rare, due to the dust prevention in mines. In the older patient cardiac decompensation versus emphysema may worry the physician, especially since both can be present. The patient with emphysema can develop a cor pulmone and suffer from heart failure from either the right or left side of the heart. With the failing heart there should be evidence of congestive failure with a swollen liver and edema of the feet. Emphysema will cause some swelling of the neck veins. The physician must determine whether the liver is enlarged and swollen or pushed downward by the flattened diaphragm. The careful history and a good physical examination should help clear up the dilemma.

The early treatment of emphysema consists of the use of broncho-dilator aerosols and preparations such as aminophyllin and ephedrine. A good expectorant cough preparation, especially one containing potassium iodide to keep bronchial secretion loose, is indicated. If the patient has an allergic asthma this should be treated by a competent allergist. With these drugs there is the possibility of a refractory state developing. If such happens, and it often does, especially with an acute cold, then the patient is in serious condition. Bed rest with the proper antibiotic to overcome the infection is urgently needed. Demerol 50 mgs. can be given by mouth or hypo three or four times daily for a period of three or four days. Oxygen by nasal catheter may be necessary for the first few days. Pneumoperitonium may be helpful. This helps to raise the diaphragm

which in turn will aid in the exchange of air in the lungs. This measure also is advocated when the emphysematous patient has to undergo surgery and evidence of cyanosis developes.

After the acute emergency is over and the patient becomes ambulatory, the following measures are indicated.

1. On arising in the morning the use of a nebulizer inhalant of Vaponephrin or Isuprel for three or four deep inspirations.

2. Manually elevating the diaphragm with the palms of the hands underneath the ribs pushing upward and inward during the last half of expiration. This is to be done 10 or 12 times leisurely, either lying in bed or sitting up.

3. After the use of the vaporizer the patient should deliberately try to cough to raise any mucous present.

4. Aminophyllin three to five grains, or Glucophyllin should be taken with a half glass of water before breakfast and in the afternoon.

5. The patient should practice diaphragmatic breathing.[3] He can do this at first by lying down with one hand on the abdomen and one on his chest, and he should attempt to see that the abdomen protrudes forward during inspiration with little or no chest movement. After he becomes accustomed to this, the same exercise should be undertaken sitting up and later walking.

6. A two-band belt to support the lower abdomen and elevate the diaphragm can be tried.

7. In the mid-afternoon and before the patient retires a nebulizer should be used to dilate the bronchi, followed by coughing to clear the bronchial tree.

8. Potassium Iodide should be taken three times daily before meals if necessary to loosen bronchial secretion.

9. Intermittent inhalation of oxygen by some method for 20 to 30 minutes two or three times daily may help in overcoming the patient's weakness and improve his exercise tolerance.

Other suggestive measures are intermittent and positive pressure breathing with the Drinker type of respirator or other instrument using oxygen. Ceepryn, a wetting agent can be added to the broncho dilator drugs to liquify and increase the bronchial secretion. Following its use if the patient is not too dyspneac, postural drainage can be attempted. Having the patient give a forced cough about the end of expiration may help lessen the carbon dioxide remaining in alveoli and also to free the bronchial tree of secretion.

Any acute respiratory infection needs adequate treatment with antibiotics. The above therapeutic methods should decrease the patient's dyspnea and weakness and make life much more tolerant, and even permit him to return to light work. One should call attention to the danger of giving excessive concentration amounts of oxygen to the patient suffering from emphysema with marked cyanosis. Giving 100 per cent oxygen may cause a rapid change in Ph and can lead to unconsciousness.

As in every chronic condition, prevention is more important than trying to cure after the condition occurs. The prevention of spinal curvature by proper posture in the older person, and exercise might help—provided we see the patient in time. The prevention of whooping-cough and chronic bronchitis in childhood by the recognized means may prevent bronchiectasis in later life. Also effective treatment of asthma, bronchitis and bronchiectasis may stop the development of emphysema, since once the condition is established, even with the best known present treatment, emphysema tends to be progressive to limit the patient's activities and to ultimately incapacitate him.

SUMMARY

1. A few new suggestions have been added in the treatment of the emphysematous patient.

2. The use of the proper antibiotic in acute respiratory infections may help to prevent aggravation of emphysema.

3. The use of aerosols in the treatment of infections and also to loosen bronchial secretion is helpful.

4. Pneumoperitoneum may help the advanced emphysematous patient in an emergency such as a prostatectomy, or other conditions not involving an abdominal incision.

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SURGICAL LESIONS OF THE CHEST IN CHILDREN

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Thoracic surgery has come into its own in the past 15 years. Rapid advances in the fields of anesthesiology, bacteriology, antibiotic therapy, and the more accurate knowledge of the physiology of respiration have given great impetus to the surgical approach to numerous chest wall and intrathoracic lesions. The surgical lesions of the chest in children differ somewhat from those in the adult, in that they are frequently on a congenital or developmental basis which require early or immediate corrective measures to either save the patient's life or to create a situation compatable with life. Thoracic surgeons have learned that newborns tolerate early corrective procedures remarkably well when given good supportive therapy, and therefore procedures of rather great magnitude can be undertaken in the first few days of life with good results. I shall not consider those cardiovascular defects for which corrective measures have become standardized, in this paper.

Lesions of the Thoracic Cage

Severe infections of the chest wall are not common lesions in children. These were much more common before the advent of the sulfa drugs and antibiotics. Empyema necessitatis or spontaneous tuberculous fistulae are fortunately things of the past. One still occasionally encounters mycotic infections of the rib cage which have their primary seat in the underlying lung parenchyma and which invade the Thoracic wall. In these instances it is sometimes necessary to make the diagnosis by biopsy. The response of these infections to medical therapy is frequently most gratifying.

It is well known that the thoracic cage in children is quite pliable. For this reason compression of the chest wall may produce extensive intrathoracic trauma without producing associated rib fractures. Severe compression injuries such as those produced by concussion or by the wheel of a car, may produce nothing more than traumatic asphyxia without any other associated injuries. On occasion one may encounter rupture of one of the main bronchi following trauma of this sort. With healing, stenosis of the bronchus and atelectasis of the respective lung or lobe of lung may ensue. This condition may not be recognized until long after the original injury has taken place.

Pectus excavatum or funnel chest is one of the more common deformities of the chest. In this condition the sternum is depressed and the cartilages adjoining the sternum are deformed and a large, hollow groove-like deformity of the chest results. The etiology of this defect is not entirely understood, but it is believed to be the result of abnormal ligamentous attachments between the midportion of the diaphragm and the lower end of the sternum. During the respiratory motion of the diaphragm there is continuous tugging on the rather mobile lower portion of the sternum causing retraction. The importance of surgical treatment for it has not been recognized and instituted until recently. If this condition is permitted to progress, extreme chest deformity may result with marked displacement of the heart and mediastinal structures or compression of those structures. Cardiac failure may result from this. It is therefore being advocated at the present time to correct this deformity at an early age. In the very young, nothing more than freeing the sternum from the diaphragm may be necessary. In the more advanced ages when the deformity has become fixed much more extensive surgery with the freeing of the entire sternum and fixing it in normal position is the procedure to be carried out.

Tumors of the ribs are among the more common lesions of the chest wall in children. Both benign and malignant tumors can occur. Cartilagenous tumors of the bony chest wall are the most common type of primary tumor in this region. Any tumor that occurs in bone may also arise in the ribs and in the sternum. The more common rib tu-

mors are designated as chondroma, chondrosarcoma, osteochondroma and osteochondrosarcoma. Other tumors are giant cell tumors, Ewing's sarcoma, osteoma, fibrosarcoma and hemangioma.. Primary malignant tumors of rib and sternum comprise about 10 per cent of all primary malignant bone tumors. About 80 per cent of all the tumors of the bony thorax arose in ribs and 20 per cent in the sternum.

The most common symptom is the appearance of a tumor mass. Pain, if present, is usually one of three types: (1) local pain, dull and aching, (2) Pleuritic pain which may occur in cases where the bulk of the tumor is intrathoracic, and (3) neuritic pain referred along the the distribution of an intercostal nerve. The diagnosis is usually made by x-ray confirmation of a palpable mass.

I feel that radical surgical extirpation of the tumor is the accepted therapy of choice in most cases. It is important to remove long segments of the involved ribs. The intercostal muscles above and below the tumor should be removed. Even benign tumors have a tendency to recur, therefore adequate excision is mandatory.

Pleural Space

The most common condition encountered affecting the pleural space alone is empyema. The frequency with which this condition is being seen has been remarkably reduced in the past few years. Ten years ago winter would see hospital wards filled with cases of pneumonia and its frequent complication —empyema. With the advent of the sulfa drugs and antibiotics pneumonia has been well controlled. Since most empyema of childhood is postpneumonic in origin it is now being seen less frequently. Occasionally postpneumonic empyemas in patients who have not been treated with antibiotics are still seen. Occasional cases are encountered where the empyema and the antecedent pneumonia has been treated by antibiotic therapy but the infection has been refractory. In such instances there is a definite change in the characteristics of the empyema fluid. It is not purulent but serous in nature. On culture it may be sterile and the empyema wall is less thick due to a lesser degree of deposition of fibrin over the pleural surfaces.

With the advent of antibiotics the treatment of empyema has changed. Formerly it was necessary to institute open drainage on all cases. In acute empyemas today, repeated aspirations with instillation of antibiotics may produce complete obliteration of the empyema space and thus lead to a cure. At times the empyema may become loculated and adequate aspiration is not possible. Rib resection for drainage of an empyema cavity often was fraught with an undesirable sequence of events. Re-expansion of the underlying lung following rib resection often took many weeks or months. In growing children it not infrequently resulted in chronic chest deformities, due to the scarring of the parietal pleura. Occasionally it resulted in permanent scoliosis.

Since World War II, pulmonary decortication has become the procedure of choice. The principle of pulmonary decortication that was first used in the treatment of hemothorax of traumatic origin is now being used routinely in the treatment of such chronic empyema. By removing the fibrous peel of infected granulation tissue from the surface of the lung, diaphragm and chest wall, the normal functions of these structures are restored. The lung fully expands and there is no resultant deformity of the chest cage or spine.

LUNGS

Cystic Disease of the Lung

Somewhat longer than a decade ago, congenital cystic disease of the lung had a formidable prognosis. In a review up to 1935, Schenck and Stein stated that although adults might live for many years with pulmonary cysts, the condition in children and infants carried the gravest outlook and early death was frequent. They also concluded that, "No specific treatment can be offered. Many cases present a surgical problem and future thoracic surgery in infants and children must meet the challenge." In 1943, seven years later, Fischer and associates reported a successful lobectomy for congenital cystic disease of the lung in a four week old infant. Since that time this feat has been repeated innumerable times and even in much younger infants.

The symptomatology of a given cyst depends on the original anatomical status together with post natal changes affected by respiratory action and infection. A small cyst may give no signs or symptoms and occasionally larger cysts may persist into adult life before their presence is suspected. The symptoms may be caused by severe compression of normal tissue by a large cyst. It may become manifest by infection of the

cyst or may cause symptoms by rupture of the cyst causing a tension pneumothorax. It is not infrequently the cause for respiratory difficulty in the newborn.

Congenital cysts are less common than acquired cysts which appear as a consequence of inflammatory reactions. Congenital pulmonary cysts may be single or multiple, localized or scattered; they may or may not communicate with a bronchus and may contain fluid, gas, or both.

Various forms of surgical therapy have been applied. Enucleation of the cyst or the removal of pulmonary tissue is by far the treatment of choice. Segmental resection, lobectomy, or even total pneumonectomy may be necessary. This is the most rapid method of restoring normal respiratory physiology. Other less desirable methods of treatment are, passage of a needle through the chest wall into the cyst cavity, permitting withdrawal of entrapped air. This is only a temporizing measure and does not cure the condition. A catheter may be passed through a trocher and introduced into the cyst for more prolonged aspiration. Marsupialization of the cyst onto the chest wall with destruction of its membrane by curettage, cauterization, or packing is another less desirable method.

Bronchiectasis

Bronchiectasis is primarily a disease of youth and early adult life and it is a disease which if not treated in proper time will often prove fatal. People who develop severe bronchiectasis in childhood rarely live beyond the age of 35.

Bronchiectasis is a common disease which has been overlooked, wrongly diagnosed and poorly treated by a majority of medical men for many years. Too often children with typical pictures of bronchiectasis have been diagnosed as chronic bronchitis or their parents have been told that the child's cough was habitual and that he or she would eventually outgrow it.

Three factors are usually present in the development of bronchiectasis. Obstruction of a segment or segments of the tracheobronchial tree, atelectasis of the surrounding lung parenchyma, and infection distal to the site of obstruction. With the non-aeration of the alveoli there is a dilation of the bronchi. If re-aeration does not occur, infection of the bronchial wall results, with destruction of the cartilages, muscles and other supporting tissue. As fibrosis occurs, the bronchi are still more susceptible to the pressure change within the chest and the dilation becomes more severe.

Cough is the most common symptom of bronchiectasis. In all cases except so-called dry bronchiectasis the cough is associated with the production of non purulent sputum. It must be remembered that almost all children up to the age of seven, and even many adults, will swallow their sputum. The sputum in many cases has an offensive odor. Bronchiectasis is probably the most common cause of hemoptysis in adults. Wheezing is another fairly common symptom, especially in children. Dyspnea is seen in far advanced cases or associated with complications.

Any patient with a history of cough, particularly on arising and upon retiring, associated with a pea soup sputum, with or without clubbing of the fingers, is entitled to, and should have bronchograms to rule out bronchiectasis. The diagnosis cannot be definitely made on plain chest x-ray films. However, the diagnosis can be made definitely only by instilling iodized oil into all of the branches of the tracheo-bronchial tree.

The treatment of bronchiectasis is that of prevention and once developed is one of extirpation. Obviously the use of immunization against whooping cough should be routine. All infants and children with any of the acute exanthematous diseases are potential candidates for bronchiectasis. Clearing up of allergies to eliminate asthma may prevent some cases from developing bronchiectasis.

After bronchiectasis becomes irreversible there is no hope for a cure except by surgery. Until the development of a one stage lobectomy by Brunn in 1929, treatment was largely palliative. With the recent advances in thoracic surgery the operative procedure can be carried out with a very low mortality rate. The amount of pulmonary tissue removed depends on the amount of tissue involved in the process. Resections may involve segments of lobes, lobes or an entire lung. Obviously enough functioning pulmonary tissue must be present to allow normal activity before resection is considered. The risk of resection is slight compared to the risk of the patient keeping his diseased lung tissue.

Lung Abscess

Most lung abscesses in children are nearly always due to aspiration either of foreign

bodies or of contaminated blood clots secondary to pharyngeal or intra-oral surgical manipulation performed under general anaesthesia. Lung abscesses in children are not as commonly seen as was true a number of years ago. Many more tonsillectomies and other pharyngeal or intra-oral procedures were done at that time and the technic for those procedures was not as well developed. When lung abscesses occur in children intensive antibiotic therapy many times will cause rapid healing of the parenchymal lesions. If the lung abscess becomes chronic and this is generally after a period of about four to six weeks, following recognition of it, either drainage of the lung abscess or resection of the involved pulmonary tissue is certainly the procedure of choice.

Multiple lung abscesses may occur from other foci of infections of the body. These are best handled by treatment with antibiotics. These patients are usually critically ill and surgical intervention is frequently of little avail unless the source of the pyemic abscesses can be controlled.

A localized abscess may rupture into the free pleural space giving an empyema with or without a bronchial communication. These cases are best handled by drainage in the very acute cases or preferably by decortication of the empyema cavity and resection of the involved pulmonary tissue.

Mediastinum

The most common mediastinal tumors in children are the lymphomas. Hodgkin's disease and lymphomas with mediastinal lymph node involvement are seen more frequently than benign mediastinal tumors but the diagnosis of lymphomas can usually be made in children by means other than thorocotomy and exploration. Benign tumors of the mediastinum are uncommon, and nearly all of those tumors which occur in adults may occur in children. Such lesions are demoid tumors of the anterior mediastinum, bronchogenic cysts, neurogenic tumors of the posterior nerve chain and many others. The technic of their removal depends on their location. Mediastinal tumors may present symptoms by exerting pressure on structures, such as pressure on the trachea, esophagus, large vessels or heart, or they may present symptoms by causing a shift in location of structures and altering the normal respiratory and circulatory physiology of the chest. These tumors are best removed at an early age.

Diaphragm

The development of the diaphragm and the descent of the stomach, as well as the formation of the pleural and peritoneal cavities, makes the diaphragm susceptible to weak areas through which hernias may occur. They may be present at time of birth or they may develop later in life.

The complex separation of the celomic cavity into pleural, pericardial and peritoneal cavities begins in the 2.1 m.m. embryo. It is completed in the 20 m.m. embryo. If a hernia of a portion of the gut occurs before this division is completed, the loops of the bowel will not be covered by serous membrane. The hernia would not be a true one. If the hernia occurs after the serous cavities are formed but before the muscular elements of the diaphragm have completely fused, the bowel would be covered by serous membrane. It would then be a true hernia. The communication between the pleural and peritoneal cavities closes in the third month of intrauterine life. Muscle fibers grow in between the pleural and peritoneal cavities and form the diaphragm.

The congenital defects of the diaphragm encountered are usually of two types. The first is an eventration of the diaphragm. These patients have atrophy of one leaf of the diaphragm with complete absence of diaphragmatic musculature with the presence of the pleural and peritoneal layers. In such infants or children, one hemithorax, usually the left is filled with abdominal contents. Occasionally, only minimal symptoms may be present, but more often such children will develop respiratory difficulties and obstructive gastrointestinal symptoms. Repair is usually attempted by trying either to plicate the extremely thinned out diaphragm, or actually to reconstruct the diaphragm by using fascia or muscle flaps.

The second diaphragmatic defect encountered in infants is the hernia of Bochdalek, which is due to improper muscularization of the posterior portion of the diaphragm. This area of the diaphragm will be covered by a pleuro-peritoneal layer. Herniation of intra-abdominal organs may occur. At times infants and occasionally newborns, represent acute surgical emergencies. They show marked respiratory impairment, cyanosis and obstruction of the gastrointenstinal tract at the esophageal-gastric junction or at the duodenal level. Thoracotomy in such instances is imperative and life saving.

In summarizing the symptoms and signs of congenital diaphragmatic hernia, it should be emphasized that the symptoms are severe. Death is frequently caused by asphyxia or intestinal obstruction. Respiratory, circulatory, gastrointestinal, or a combination of these three main symptom complexes may be present. If there is dyspnea, cyanosis or vomiting during crying or nursing following delivery, immediately consider a congenital diaphragmatic hernia in the differential diagnosis.

Physical signs:

1. Rapid respiration and pulse rate.
2. Heart displaced from the affected side.
3. Tympany or dullness on percussion of affected side.
4. Absent or distant breath sounds on auscultation, also the presence of intestinal gurgles.
4. Scaphoid abdomen as most of the abdominal contents may be in the chest.

The suspicion of the presence of diaphragmatic hernia is the main diagnostic feature. X-ray evidence is of great value. The earlier the repair is performed the better the chance of survival of the infant. Another less common type of hernia is the Foramen of Morgagni or Parasternal hernia. The contents of this hernia are usually colon, omentum or intestines.

Esophageal Lesions

Congenital atresia of the esophagus with or without tracheo-esophageal fistula is not an infrequent occurrence. Since the tracheobronchial tree and esophagus are derived from a common anlage it is not surprising to find many various forms of malformations involving these structures. The esophagus may fail to form its usual tubular structure and be nothing but a cordlike structure. The esophagus may be stenotic or the esophagus may have a blind proximal pouch and a separate distal portion leading to the stomach. The esophagus may have a diaphragm obstructing a normal tubular organ. Communications between the esophagus and the trachea are common in these cases.

The most common type of congenital atresia of the esophagus is one in which there is a proximal pouch only, and where the distal esophagus attaches to the trachea usually in the region of the carina. This type of atresia is the most favorable for surgical treatment. The diagnosis of this type of lesion can be easily made if kept in mind in the child who regurgitates recently swallowed food and in which there is no evidence of gastric secretion in the regurgitated material. The infant usually aspirates ingested food and can become cyanotic and have paroxysms of coughing at each attempt at feeding. One should never use barium to verify the diagnosis roentgenologically in such instances; instead, lipiodol should be used in all circumstances. Passing a catheter through the nose into a blind proximal pouch can usually make the diagnosis along with gas in the gastrointestinal tract.

The first successful operation with reestablishment of continuity of the esophagus was done in 1943 by Dr. Cameron Haight. He used the extrapleural approach on the right side closing the fistula, performing an end-to-end anastomosis between the priximal esophageal pouch and the distal esophagus. This method is preferred by many men. Still others prefer the transpleural route.

Strictures of Esophagus

Accidental swallowing of corrosive liquids is not infrequent in children. The most common offender is still lye. The most common site for stricture is at the lower one-third of the esophagus. On swallowing the lye, the sphincter at the cardia of the stomach goes into spasm and the lye is held in the lower end of the esophagus before passing on through to the stomach; during this period of retention a severe burn occurs. During the process of healing, the esophagus, particularly if it has had early and enthusiastic dilatations, will show severe cicatrix formation up to the point where the child will be unable to swallow soft or even liquid food. For adequate esophageal dilatation a gastrostomy is necessary and a standard procedure is to submit the child to periodic retrograde esophageal dilatation with bougies until a time at which it is felt that no further scarring and stenosis will take place. However, many times, stricture formation will occur many months or even years after the initial injury leading to continued difficulty which cannot be relieved by dilatations. Surgical therapy is now being undertaken in increasing numbers. The method most frequently used is resection of the strictured portion of the esophagus, mobilization of the stomach and re-establishment of the continuity of the gastrointestinal tract by esophagogastrostomy.

THE MANAGEMENT OF URETERAL CALCULI

E. N. LUBIN, M.D.
TULSA, OKLAHOMA

A perusal of the literature pertaining to the management of ureteral calculi will compound the confusion and uncertainty felt by urologists. One author will report astounding success by means of operative cystoscopy.[1,2,3,4] Another author will stress the hazards and complications of the same procedures.[5,6,7,8] Much has been written concerning the criteria for management of ureteral calculi[8,9,10,11,12] and certainly a cautious, conservative, middle-of-the-road course is generally advocated. However, little has been published, in recent years, about hospital stay and morbidity—particularly since the advent of the anti-biotics.

This study consists of an analysis of 285 consecutive admissions for ureteral calculi in a 500 bed general hospital over the five year period, 1946-50 inclusive.

FIGURE 1

Admissions	285
Patients	249
Cases treated by Surgery or Operative Cystoscopy	220
Average Age	42.7 years
Males	215 or 76 per cent
Females	70 or 24 per cent
Right Ureter	129 or 48 per cent
Left Ureter	139 or 52 per cent
One Stone	242 or 95.3 per cent
Two Stones	10 or 3.9 per cent
Three Stones	2 or .8 per cent
Total Stones	268
Questionable Cases	31

Position of Stone, Age and Sex

The analysis presented in Figures 1 and 2 are comparable to those presented by Bumpus and Thompson[10], Higgins and Warden[8], McKay, Baird and Lynch[9] and others.

Duration of Hospitalization and Post-operative Stay

McKay, Baird and Lynch[9] have reported a study of average hospital stay based on operative or operative cystoscopy management and the position of the calculus in the ureter. (See Figure 3.) Allen[3] reports the majority of his cases treated by operative cystoscopy, with the Johnson stone basket, were discharged on the fifth post-operative day. Most authors have been very vague about this important feature in patient management.

Figure 4 presents an analysis of the duration of hospitalization. This figure is affected by the fact that several cases had unrelated illness or surgical procedures during the same admission.

Figure 5 and 6 present an analysis of post-operative hospital stay based upon the type of management employed. The figure for catheter manipulation represents that means as the only procedure attempted.

Examination of the above figures reveals that all forms of operative cystoscopy entail approximately an equal length of convalescence. One also notes that operative cystoscopy prior to ureterolithotomy does not lengthen hospital convalescence. The fact that 41 per cent of the cases required three days or less postoperative stay would tend to relegate the treatment of ureteral calculi to the status of a relatively innocuous procedure.

FIGURE 2

Position of Stones

	Number	Percent
Upper Ureter	29	11 per cent
Middle Ureter	26	10 per cent
Lower Ureter	213	79 per cent

FIGURE 3

Analysis of McKay, Baird and Lynch

Location of Stones	Average Hospital Stay, Days
Upper part of ureter (20 Cases)	
Operative	17
Operative Cystoscopy	9
Middle part of ureter (11 Cases)	
Operative	13.5
Operative Cystoscopy	14.5
Lower part of ureter (90 Cases)	
Operative	16
Operative Cystoscopy	7.3

FIGURE 4

Duration of Hospitalization of 285 Cases

Average stay	7 days
51 per cent cases	5 days or less
78 per cent cases	10 days or less
10 per cent cases	14 days or more

FIGURE 5

Post-operative Stay 220 Cases

Average stay	5.8 days
41 per cent cases	3 days or less
72 per cent cases	7 days or less
6 per cent cases	14 days or more

Morbidity

The proper evaluation of any therapeutic procedure must, of necessity, include a consideration of the associated morbidity and mortality. There is a paucity of references to the morbidity associated with ureteral calculi. For this reason the analysis in Figure 7 is particularly interesting. Fever of 99.4° or more was used as the criterion of morbidity for this study. These figures indicate that patients treated by operative cystoscopy have a febrile response in one-fourth or less of the cases, whereas open surgical treatment is complicated by a febrile response in practically all cases. However, there is little difference in the duration of fever when it occurs, regardless of the procedure used.

A comparison of Figures 6 and 7 indicates that operative cystoscopy does not adversely affect either morbidity or post-operative stay when subsequent ureterolithotomy is carried out.

Results and Complications

The calculus was recovered in all cases undergoing ureterolithotomy. This favorable result can be attributed to the general policy of taking pre-operative x-ray films.

The overall percentage of successful operative cystoscopies was generally less than has been reported by others.[1,2,3,4,8] One explanation of this finding may be the author's lack of post-hospitalization follow-up information. Undoubtedly many patients passed their calculi spontaneously after hospital discharge and some credit is undeniably due to the operative cystoscopy. The results of this study are shown in Figure 8.

This series is singularly fortunate in not possessing a single fatality. Only one major complication occurred and that was the perforation of a ureter with a catheter and was followed by prompt ureterolithotomy and drainage. In no case was nephrectomy required as the result of operative cystoscopy. No data is available on the subject of post-operative stricture or ureterectasis secondary to over-dilatation of the ureter.

FIGURE 6

Average Post-operative Stay According to Procedure

Basket	4.2 days
Loop	3.7 days
Catheter	3.8 days
Surgery	12 days
Surgery and Operative Cystoscopy	11 days

FIGURE 7

Morbidity as Determined by Fever of 99.4° or more 100 Cases or 45 per cent of Operated Patients

	Average Duration	Percent
Basket	3 days	25 per cent
Loop	3 days	25 per cent
Catheter	4.4 days	15 per cent
Surgery	3.9 days	100 per cent
Surgery plus Operative Cystoscopy	4.0 days	85 per cent

FIGURE 8

	Cases Attempted	Percent Successful
Basket	79	67 per cent
Loop	20	55 per cent
Catheter	68	42 per cent
Total	194	48 per cent
Upper Ureter	14	0 per cent
Middle Ureter	14	21 per cent

Summary

The hospital records of 285 consecutive admissions for ureteral calculi were analyzed from the following standpoints: Age, sex, side, number of stones, position of stones, duration of hospitalization, post-operative stay, morbidity, complications and results. The study was further sub-divided into an analysis of some of the above factors as related to different types of operative cystoscopy and open surgery.

Conclusions

1. The average duration of hospitalization and post-operative convalescence following operative cystoscopy is relatively brief.
2. There is no significant difference in

the duration of post-operative convalescence between the various forms of operative cystoscopy.

3. The duration of post-operative convalescence in ureterolithotomy is triple that of operative cystoscopy.

4. There is no significant variation in the duration of morbidity, as determined by fever of 99.4°, among the various types of operative cystoscopy and ureterolithotomy.

5. Operative cystoscopy prior to ureterolithotomy does not increase morbidity or prolong convalescence.

6. Operative cystoscopy is a safe procedure in the hands of the average competent urologist.

7. The results of operative cystoscopy, although not spectacular in the hands of the average competent urologist, merit continued judicious application of the procedure.

The author wishes to express his appreciation to Sister Superior M. Agatha and Miss Bernice Torkelson of St. John's Hospital, Tulsa, Oklahoma for their assistance in making this study.

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"TIMING" IN LABOR

BRUNEL D. FARIS, M.D.
OKLAHOMA CITY, OKLAHOMA

For the want of a better word to describe the importance of a set "time" to act during labor I must require the reader of this article to use his own discretion. "Timing" in labor may be likened to that of a batter at home plate. Split second timing when to hit the ball will determine whether the ball is hit a foul or for a base. The cardinal rules hold today as well as they did years ago. There is a time to give the sedatives and analgesics and certainly a limit to the amount to be given. A time to start the anesthesia, a time for the interference which will less jeopardize the mother and baby, a time for the application of the forceps and a time for the episiotomy which may differ according to the type of episiotomy you perform; earlier for the medial lateral, later for median. It is the opinion of many that prolonged labors and occasional fetal deaths are due to the indiscriminate use of sedatives and analgesics, there are others who believe that it is not the type of analgesic so much as the *time* that they are given. Certainly little or no sedation should be given when we believe labor will ensue within the time the baby could be drugged from its influence. Seldom does the average labor need the amount of anesthetic necessary for a major operation. The average obstetrician has had the experience of applying the forceps too early. Experience teaches him the forceps should be applied if possible at the time of a pain or contraction of the uterus and when the head has rotated as much as possible toward normal position of descent. Between contractions the head may rise until the application may be difficult for a perfect one. Obstetricians also differ on the type of episiotomy to perform. The anatomy of the female pelvis it seems should prefer the midline but many fear the chance of a third degree tear from this type. "Timing" is again important in that the midline should not be done until the head is on the perineum and there is bulging. The medial lateral episiotomy may be done earlier but there still may be a third degree tear unless the head is carefully and slowly delivered. Finally the shortest time possible should be allotted to perform an operation with due respect to efficiency. The less time the mother is under the anesthetic, the quicker the delivery and operation the less the chance for post-operative shock.

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Addition of Alidase to the first few cubic centimeters of fluid during hypodermoclysis speeds absorption to a degree approximating that of the intravenous route. Use of highly purified hyaluronidase in this manner avoids the well-known difficulties encountered with venoclysis, saves valuable nursing time and is more comfortable to the patient.

Hechter, Dopkeen and Yudell[1] have found that the use of hyaluronidase has "markedly increased the rates of absorption and administration of hypodermoclysis with no untoward reactions." They also found that extremely small amounts of this enzyme facilitated the absorption of fluids in that greater amounts of fluids were absorbed by the patient in a given period of time and that the localized swelling following hypodermoclysis disappeared more promptly.

Similar results with Alidase were recounted by Schwartzman, Henderson and King.[2] They observed "that absorption of various types of solutions, such as saline, glucose in saline, Hartmann's solution, Ringer's solution, penicillin, streptomycin, Adrenalin, and procaine was facilitated in every case."



In toxemias of pregnancy—Urgently-needed parenteral fluids may be administered subcutaneously with the aid of Alidase, eliminating risk of thrombosis attending repeated intravenous administration of electrolyte solutions. Alidase is the highly purified Searle brand of hyaluronidase and is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

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President's Page

If we sincerely wish to improve public relations and to fulfill our obligations to society and to increase our influence and usefulness, we must switch more and more to positive leadership.

Rehabilitation is a case in point.

A wreck, either a car or a person, is proof that an error of some kind has been made, but we must undertake to salvage the handicapped person and restore him to a life of usefulness, regardless of circumstances.

I wonder how many of you know that Oklahoma has a Rehabilitation Center, and of its work in returning severely disabled persons to lives of usefulness. This center is located at Okmulgee, and is operated by Oklahoma A. & M. College. I urge you to see it.

The service of this Center is but one of many services provided by the Oklahoma Rehabilitation Service, a Division of the State Board of Education. This agency during the last biennium handled 10,098 handicapped persons, and returned 2,482 to useful employment.

Yes, it is a tax-supported Department, but in this case the taxpayer MAKES money. The average cost of rehabilitation is $553.43. The average increase in earnings of those rehabilitated was $29.00 per week, which means in a very short time they pay more in taxes than the program costs.

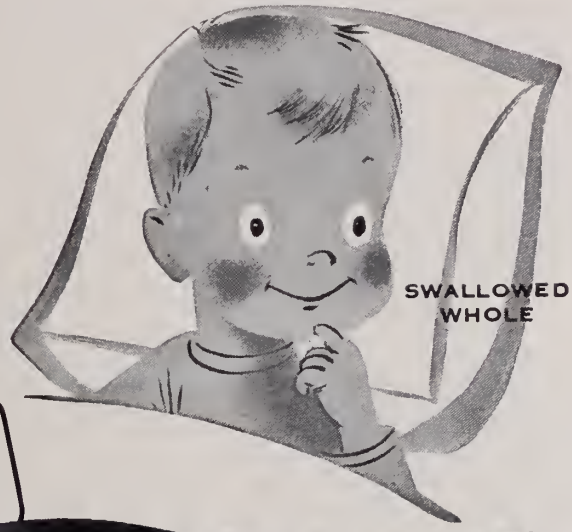
Last year the State expended $241,000 on this program. During that year it is estimated that the 2,482 rehabilitated persons mentioned above paid $374,000 in taxes. There are hundreds of families receiving aid to dependent children, because the head of the family is disabled. It is estimated that the state could save $5,000,000 in three years through their rehabilitation.

When, to this economy measure, you add the humanitarian angle with its heartwarming experience of seeing a man doing useful and dignified work rather than selling pencils, you have a bargain. Only doctors can make it go. Look into it, please.

*Statistics furnished by the Office of Rehabilitation.

Alfred R. Shugg

President



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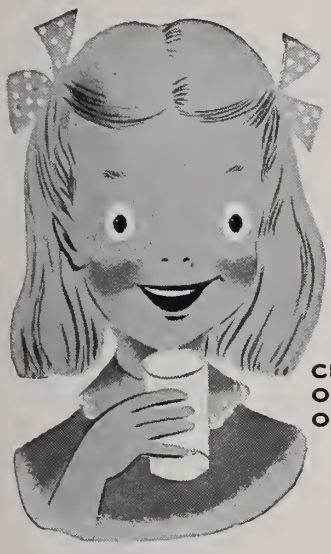
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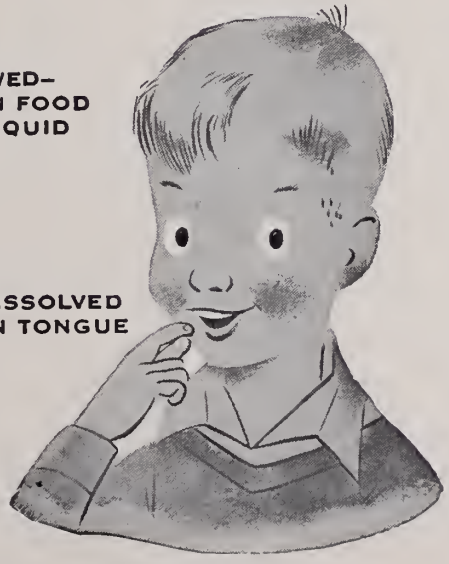
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SIXTIETH ANNUAL MEETING TO INCLUDE 43 PAPERS

A wide range of current medical interests is reflected in the titles of 17 papers to be presented at the 60th Annual Meeting of the Oklahoma State Medical Association in Tulsa, April 13-15, 1953, by nine visiting distinguished guest speakers.

Announciug the completion of the scientific program last month, Dr. Berget H. Blockson of Tulsa, Chairman of the Scieutifie Works Committee, said the program would also contain 26 other papers to be presented by Oklahoma doctors, making a total of 43 scientific lectures during the three-day convention.

Doctor Blocksom said all members of the Oklahoma State Medical Association would receive a printed program by mail early in March. The program will also be printed in the April issue of *The Journal.*

Dr. W. Alton Ochsner, Chairman of the Department of Surgery at Tulane University School of Medicine, New Orleans, Louisiaua, will present papers entitled "Surgery of the Heart and Great Vessels" and "Recent Advances in the Treatment of Hypertension."

Dr. Garfield D. Duncan, Professor of Medicine at Jefferson Medical College, Philadelphia, Pennsylvania, will discuss "Practical Aspects in the Management of Diabetes."

Dr. Francis J. Braceland, Psychiatrist-In-Chief at the Institute of Living, Hartford, Connecticut, and also Professor of Psychiatry at Yale University School of Medicine, has selected "Early Detection of the Emotional Disorders of Old Age" and "Middle Life and Mental Disease" as his subjects.

Dr. Wendell G. Scott, Associate Professor of Radiology, Washington University School of Medicine, St. Louis, Missouri, will discuss "Diagnostie Radiologic Techniques" aud "Radioactive Iodine 131 in the Treatment of Hyperthyroidism."

Dr. Allan P. Bloxsom, distinguished Houston, Texas, pediatrician, and also Professor of Pediatrics at the University of Texas School of Medicine, will speak on "The Use of a Pan-Transfusiou System" and "Resuscitation of the Newborn Infant."

Dr. F. Bayard Carter, Chairman of the Department of Obstetrics & Gynecology, Duke University School of Medicine, Durham, North Carolina, has selected "Obstetric Deaths" and "The Radical Operative Treatment of Squamous Cell Cancer of the Cervix" as his subjects.

Dr. Carl A. Moyer, Professor of Surgery, Washington University School of Medicine, St. Louis, Missouri, will lecture on "Respiratory Failure During Surgery" aud "The Treatment of Burns."

Dr. James C. Sargent, Chairman of the Department of Urology, Marquette University Medical School, Milwaukee, Wisconsin, will discuss "Bladder Tumors: Their Diagnosis aud Treatmeut" and Urolithiasis."

Dr. Paul H. Holinger, Assoeiate Professor of Otolaryngology, has chosen "Bronchogenic Carcinoma" and "The Significance of Dysphagia or the Lump in the Throat" for his presentations.

"We are most fortunate to secure such a "Who's Who of Medicine for our visiting distinguished guest speakers," Doctor Blocksom said in his anuouncement. "We hope every Oklahoma doctor will take the opportunity to hear these outstanding men of American Medicine."

Members of the Oklahoma State Medical Association who will appear on the scientific program are as follows:

Dr. B. C. Chatham, Chickasha; Dr. Frank L. Bradley, Talihina; Doctors Paul C. Benton, Robert M. Shepard, Jr., Dixon N. Burns, William R. Turnbow, Arnold H. Ungerman, Robert A. Hayne, Milford S. Uugerman, Averill Stowell, William M. Benzing, William S. Jacobs, John C. Dague, and F. L. Flack, all of Tulsa; Doctors David C. Ramsey, Henry Laurens, Jr., and Ray U. Northrip, Ada; Doctors Keiffer M. Davis and Camp S. Huntington, Bartlesville; and Doctors Brunel D. Faris, William T. Newsom, Paul M. Obert, Howard B. Shorbe, William L. Waldrop, and John Powers Wolff, all of Oklahoma City.

Two rouudtable luncheons will provide an opportunity for convention visitors to question visiting distinguished guest speakers. To be held at The Mayo at 12:15 p.m. on Tuesday and Weduesday, April 14-15, the luncheons will be informally conducted. Doctors Ochsner, Scott, Braceland, and Carter will appear at the Tuesday luncheon; Doctors Moyer, Holinger, Sargent, and Bloxsom on Wednesday.

Three sectiou meetings will be of special interest to both specialists and general practitioners attending the meeting. The Section on Neurology and Psychiatry will meet on Monday afternoon and the Section on Urology on Tuesday afternoon. On Weduesday, April 15, the conveution will close with an entire afternoon devoted to various problems of Industrial Medicine.

Medical and surgical motion pictures are to be shown each morning from 9:30 a.m. to 11:30 a.m. at the Cimarron Ballroom, headquarters for the meeting.

Convention visitors will also enjoy the commercial exhibits of fifty-five firms offering products and serviees of value to the medical profession. All doctors are urged to visit all exhibits.

The Tulsa County Medical Society reports that a heavy advance reservation is being made for the 1953 Anuual Meetiug and urges all Oklahoma doctors planning to attend to mail in the reservation card contained in this issue of *The Journal* at once. Desirable accommodatious in all major hotels were still available at press time.

ORDER TICKETS NOW FOR DINNER-DANCE

Tickets for the President's Annual Dinner Dance, a feature of the 60th Annual Meeting of the Oklahoma State Medical Association in Tulsa, April 13-15, 1953, will go on sale March 1st at the offices of the Tulsa County Medical Society, B-9 Medical Arts Building, Tulsa.

Scheduled for Tuesday evening, April 14, the Dinner Dance will feature Ralph Flanagan and His Orchestra, currently America's Number One Dance Band. The event will be held at 6:00 p.m. in the Crystal Ballroom of The Mayo.

Convention visitors planning to attend may order tickets by mail from the Tulsa County Medical Society offices. The price will be $6.50 per person, including tax. This will entitle the holder to a social hour, steak dinner, the inaugural program, and four hours of dancing to Ralph Flanagan's music. There will be no formal after dinner speech, and the program will feature musical selections aud the inauguration of Dr. John E. McDouald of Tulsa as President of the Assoeiation.

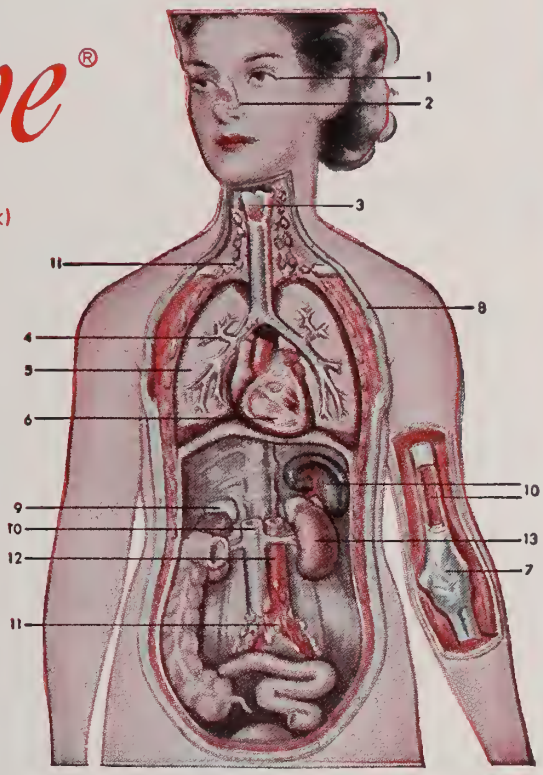
Checks should be made payable to "Oklahoma State Medieal Association." Attendance is limited to 500 persons, the capacity of the ballroom.

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EDWARD C. REIFENSTEIN, JR., M.D.
DIRECTOR



In this article, the sixteenth in the series, the current progress in the clinical cancer research section will be discussed. The program is now in full swing and it is still gathering momentum as additional equipment and facilities are becoming available. The section consists, at the present time, of several beds in the Research Hospital and the facilities of two laboratories. One of these, the central research laboratory under the direction of Dr. Charles D. Kochakian, consists of 15 units of laboratory space and, when fully manned, of over 20 technicians; this laboratory analyzes dietary, urinary, fecal and blood constituents. The second laboratory, under the direction of Dr. Leonard P. Eliel, head of the clinical cancer section, is devoted to an analysis of the constituents of cancer tissue. Both laboratories have been in operation for 10 months.

The first patient with cancer was admitted to the Research Hospital September 8, 1952, and long-term studies have been made on three patients with neoplastic disease since then. In addition, studies of short duration have been undertaken on four other patients.

The cancer research program is almost entirely supported by grants from various agencies. The largest comes from the National Cancer Institute, while substantial aid has been obtained also from the American Cancer Society and the Damon Runyon Memorial Fund, Inc. These grants provide not only for the operation of the laboratories and the salaries of the laboratory personnel, but also for the care of patients in the Research Hospital (that is, nursing care, diet and dietitians, medications, routine laboratory work, x-rays, etc.).

The chief need of the clinical cancer section at the present time is for research fellows, in order that the program can be further developed and accelerated. The American Cancer Society has recognized this need by awarding, through the University of Oklahoma School of Medicine, a clinical fellowship with an annual stipend of $3,600.00 for training and research. This fellowship will be under the supervision of Doctor Eliel. Furthermore, there is promise of additioual assistance for other qualified fellows.

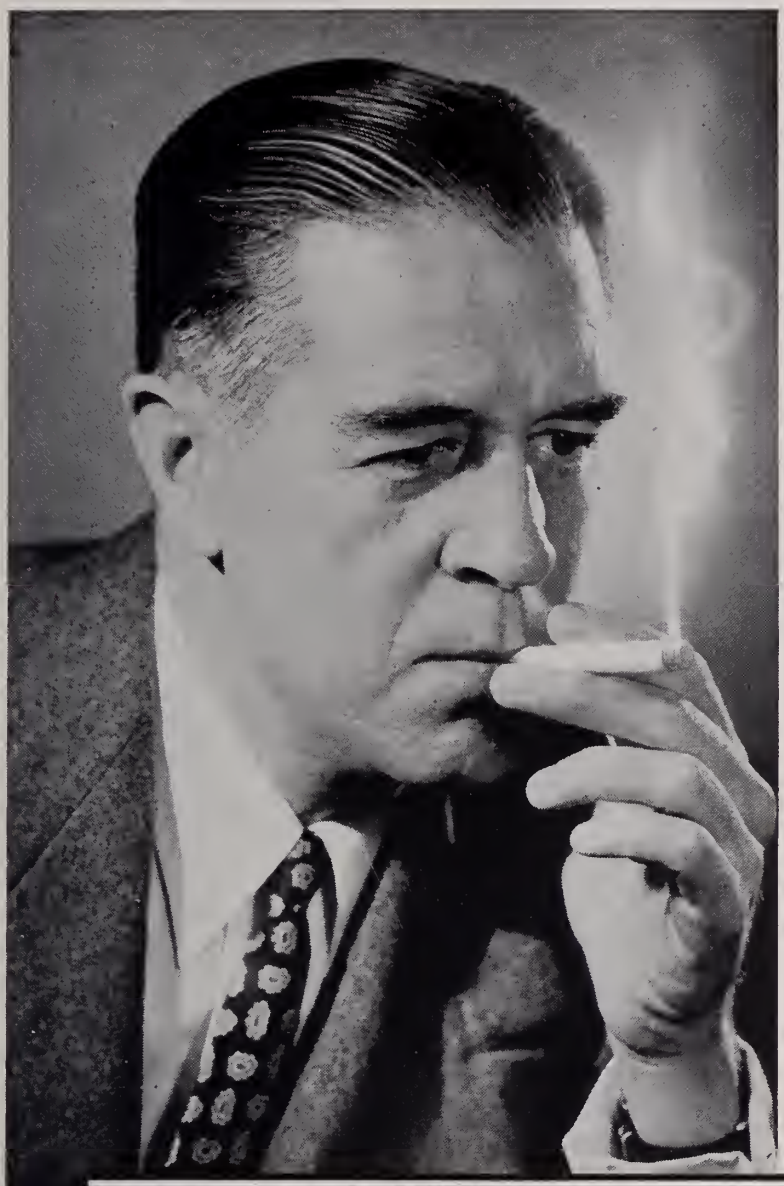
The research program at the present stage is divided into three phases of activity. The first concerns itself with the study of the mechanism of action of various agents which control the rate of growth of tissues in man. Thus, there is being investigated on the body economy of nitrogen and various electrolytes the effects of agents such as adrenal and sex hormones, nitrogen mustard-like compouuds, anti-folic substanes, and ionizing radiation. Alterations in the composition of normal and neoplastic tissue are being determined. Changes are being induced in the protein and electrolyte environment of the cancer cell in order to observe the effect of such changes on the growth of the cell. Patients in this phase of the program are studied by means of the metabolic balance technique, which involves the determination of the total intake and output of nitrogen and electrolytes. The urinary excretion of creatine, creatinine and 17-ketosteroids also is determined.

One study in this first phase has been completed. The metabolic effects of triethylene melamine (TEM) have been studied in a patient with giant follicular type of lymphosarcoma. The amount of tumor mass in this patient apparently was relatively small, since shrinkage of the tumor was not reflected by any marked increase in excretory products. There was, however, a striking shift in the nitrogen balance; the patient consistently lost nitrogen from her body prior to the administration of TEM, whereas afterwards she exhibited definite retention of nitrogen, indicating anabolism of normal tissue. This anabolism was associated with marked symptomatic improvemeut. Tissue analyses of this study are still in progress.

The second phase of the cancer program involves an investigation of the effect of various blood protein fractions ou the course of leukemia. This study was stimulated by the observation that in leukemia exchange transfusions (in which the entire blood volume is replaced by transfused blood) are sometimes followed by temporary hematologic and clinical remissions. This suggests that there may be a factor in normal blood which is missing from leukemic blood, and which can be administered in sufficient amount to induce a temporary remission of the disease. To test this, several plasma and red-cell proteins are being given to patients with various types of leukemia. At this writing, each of two boys with acute leukemia have been given approximately 125 gm. of human serum albumen, and one adult with a monocytoid type of leukemia has received approximately 80 gm. of modified human globin (the protein fraction of the hemaglobin molecule). Thus far, there has been no objective evidence of improvement with these proteins. However, further investigation is required in other types of leukemia, and with other kinds of plasma-protein fractions.

The third phase of the program involves an investigation of the effects of enzyme inhibitors on the growth of cancer tissue. One patient with adrenal cortical carcinoma was studied for 75 days in the Research Hospital. Her urinary output of 17-ketosteroids was approximately 20 times normal, and she also excreted in the urine very large quantities of a substance with chorionic gonadotropin-like properties. These excreted substances are presumed to have been produced by the extensive tumor. Since male hormones have been shown to cause atrophy of the adrenal cortex in animals, large doses of an androgenic hormone were administered to the patient in the hope it would cause tumor regression, but no change was observed. Subsequently, she was given isonicotinic acid hydrazide in the hope that this substance might compete with nicotinic acid in one of evidence that this substance retarded the growth of the enzymes which is required for the metabolism of

(Continued on Page 80)



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OBITUARIES

D. W. GRIFFIN, M.D.
1873-1953

D. W. Griffin, M.D., Norman, pioneer in the state's mental health program during his 50 years' service at the Central State Hospital, died January 1. He had been in ill health since he retired at Central State Hospital superintendent in 1949.

Doctor Griffin was born near Lenoir, North Carolina, October 28, 1873, and received his medical degree from Richmond, Virginia. He came to Indian Territory in 1899. He became superintendent of Central State Hospital in 1910.

F. R. FIRST, SR., M.D.
1888-1953

Francis Ray First, M.D., well known Oklahoma physician from Checotah, died in a Tulsa hospital January 31 following a short illness.

Doctor First, a graduate of Kansas University Medical School, practiced in Tulsa, Crescent and Barnsdall before going to Checotah. He began practicing in 1915.

Survivors include the widow of the home and two sons, Francis R. First, Jr., M.D., Checotah; and Safety First, M.D., Tulsa; and one daughter, Mrs. N. L. Garton, Joliet, Ill.

I. V. HARDY, M.D.
1870-1953

I. V. Hardy, M.D., Medford, Grant county physician for more than 50 years, died January 12 at an Enid hospital. His activities had been limited since suffering an injury in a fall eight years ago and he had been confined to his home for the past three years.

Doctor Hardy was born at St. Joseph, Mo., October 28, 1870. He studied medicine in Kansas City. Dr. and Mrs. Hardy were honored in November, 1951, with a party complimenting their "50 years of community service." At that time he received an O.S.M.A. 50 Year Pin.

WILLIAM A. TOLLESON, M.D.
1869-1953

William A. Tolleson, M.D., pioneer Eufaula physician, died January 24 in a Muskogee hospital.

Doctor Tolleson was born near Charleston, Arkansas, December 31, 1869. He studied in Arkansas under preceptors and also attended Barnes and Missouri Medical College. He began practice at Keokuk Falls, near Shawnee, and practiced in several other towns in Oklahoma before moving to Eufaula. He qualified with the Creek Board on Credentials in 1900. He joined the Indian Territory Medical Association in 1897 and was president in 1904. Doctor Tolleson was presented an O.S.M.A. 50 Year Pin several years ago.

He was a member of the Baptist church, a Master Mason and had served many terms on the City Council at Eufaula. He was a charter member of the Lions Club of Eufaula and had been president on three occasions.

RESOLUTION

WHEREAS, David Wilson Griffin, M.D., Professor Emeritus of Psychiatry and Neurology, having served on the faculty since September 1, 1916; beginning as Associate Professor of Psychiatry and Neurology and Medical Jurisprudence; gave of his best for the relief of suffering of others, and set an example which will long continue to influence and inspire us, died on January 1, 1953, and

WHEREAS, by the death of Doctor Griffin, the Medical Profession, the State, the Faculty of the Oklahoma University School of Medicine, and those who have depended upon him for help and counsel have a great loss, and

WHEREAS, we, the members of the Faculty of the Oklahoma School of Medicine, feel a keen sense of loss, both personal and professional, in the passing of our fellow member and desire to convey to the world our appreciation of his devoted service.

THEREFORE, BE IT RESOLVED, that we express to his relatives our sincere sympathy and our desire to share their great loss, and

BE IT FURTHER RESOLVED, that a copy of these resolutions be sent to the relatives of Doctor Griffin, a copy spread on the records of the faculty, and a copy sent to the *Journal* of the Oklahoma State Medical Medical Association.

—Committee on Resolutions.

January 8, 1953

RESOLUTION

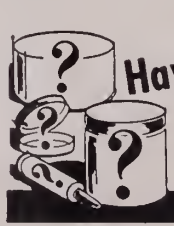
The Garvin County Medical Society feels a deep loss in the death of Dr. John R. Callaway. He long served this society in every office—for many years as secretary, and his records in that office are an accurate chronical of the actions and deliberations of this group —a record not surpassed in fullness and detail.

We, his colleagues, have lost a friend; Oklahoma has lost a pioneer of medicine and to many people of Garvin County the best and most compassionate of doctors, a grand and wonderful friend can never be replaced.

The history of pioneer medicine in Oklahoma has been written and Dr. John Callaway furnished material for a large chapter in that book. His greatness will be measured in time in the minds, the hearts and the lives of his many friends.

s/ J. A. Graham, M.D.
President

Hugh Monroe, M.D.
Secretary


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ANNOUNCEMENTS

AMERICAN ACADEMY OF GENERAL PRACTICE. St. Louis, March 23-26.

OKLAHOMA STATE MEDICAL ASSOCIATION. Tulsa, April 13-14-15. House of Delegates April 12.

AMERICAN COLLEGE OF PHYSICIANS. Atlantic City, April 13-17.

AMERICAN MEDICAL ASSOCIATION. June 1-5, New York City.

NATIONAL TUBERCULOSIS ASSOCIATION. May 18-22. Los Angeles.

AMERICAN ASSOCIATION OF THE HISTORY OF MEDICINE. Annual Meeting to be held with the sesqui-centennial celebration of Ohio at Columbus, Ohio April 10, 11, and 12. Dr. Linden F. Edwards, Department of Anatomy, Hamilton Hall, Ohio State University, Columbus 10, Ohio, is chairman of the program and arrangements committee. All interested persons are invited to attend.

SOUTHWEST ALLERGY FORUM. Kansas City, Missouri, Hotel Muehlebach, June 14-15-16. Those interested in participating in the program are invited to write the president, Orval Withers, M.D., Bryant Building, Kansas City 6, Mo. For information write Frederic Speer, M.D., Secretary-Treasurer, 2601 Parallel Ave., Kansas City 4, Kans.

AMERICAN CONGRESS OF PHYSICAL MEDICINE AND REHABILITATION. Palmer House, Chicago, August 31, September 1-4. Full information may be obtained by writing to the executive offices, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Ave., Chicago 2, Ill.

TUBERCULOSIS SYMPOSIUM FOR GENERAL PRACTITIONERS. Saranac Lake, New York, July 13-17.

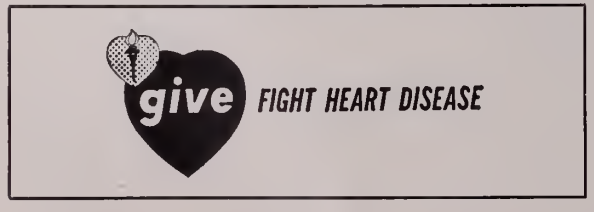
COLLEGE OF MEDICAL EVANGELISTS ANNUAL POSTGRADUATE CONVENTION. Ambassador Hotel, Los Angeles, March 8-10.

BOOK REVIEW

TUBERCULOSIS. Saul Solomon, M.D. Coward-McCann, Inc. New York. 1952. Price $3.50.

In the Coward-McCann Health Series, this book by Saul Solomon, M.D. will answer many questions constantly arising in the minds of physicians, patients, nurses, public health workers and a curious public recently rendered more curious by unwarranted publicity about so-called miracle drugs in the treatment of tuberculosis. The book, designed for the non-medical reader, is well written and easily understood. A glossary explains medical and technical words and terms and there is an index for the convenience of the reader. The book might well be in every physician's reception room and in the libraries of every tuberculosis society and public health agency.

It is readable, thought provoking, educational and timely.—Lewis J. Moorman, M.D.



MEET OUR CONTRIBUTORS

Martin Leibovitz, M.D., Tulsa, is the author "Surgical Lesions of the Chest in Children." He was graduated from the University of Illinois School of Medicine and practiced in Iowa City and Des Moines, Iowa, and Chicago, before coming to Oklahoma. His specialty is thoracic and cardio-vascular surgery and he is a Fellow of the American College of Surgeons, has been certified by the American Board of Surgery, and is a member of the American Trudeau Society.

E. N. Lubin, M.D., Tulsa, wrote "The Management of Ureteral Calculi: An Analysis of 285 Consecutive Cases" in this issue. Doctor Lubin, whose specialty is urology, had been certified by the American Board of Urology. He was graduated from the State University of Iowa and interned at Iowa Methodist Hospital, Des Moines. He served his residency at Jefferson Medical College Hospital, Philadelphia.

Walker Morledge, M.D., Oklahoma City, has a paper on "Emphysema" in the March *Journal*. Doctor Morledge was graduated from Western Reserve University in 1919 and interned at Cleveland City Hospital. He served his residency at University of Oklahoma Hospitals and also did postgraduate work in South Africa and London. His specialty is internal medicine.

Brunel D. Faris, M.D., Oklahoma City, a graduate of the University of Oklahoma School of Medicine, wrote the paper on "Timiug in Labor." Doctor Faris interned in Chicago and served his residency in obstetrics at Wesley Hospital, Oklahoma City. His specialty is obstetrics and gynecology.

CURRENT ACTIVITIES AT THE OKLAHOMA MEDICAL RESEARCH FOUNDATION

(Continued from Page 76)

steroid hormones in the tissues. Again, there was no the tumor, although there was a suggestion that the excretion of steroids and gonadotropins may have been reduced. The patient died recently, and two and one-half kilograms of tumor were removed from the liver at autopsy. The tumor mass now is being analyzed for the hormone substances that were found in the urine.

Work with radioactive isotopes was begun in February, 1953. The isotopes are being used as tracer substances in the balance investigations. They will yield informatiou concerning the distributiou and the quantity of potassium sodium, chloride, and sulfur in the body. The facilities of the isotope laboratory in the Oklahoma Medical Research Institute are being utilized in these studies.

Investigations to be undertaken in the near future will involve the effects of varying the protein and electrolyte environment of the body on the growth of tumors. Some studies will be made also on the physiology of the adrenalectomized human, since adrenalectomy has been used extensively as an experimental approach in the control and palliation of cancer.

The Clinical Cancer Section is in need of suitable clinical material for its beds in the Research Hospital. Patients with advanced cancer not amenable to surgery or x-ray, who are still in relatively good condition, are desired. Physicians with such patients, who might be interested in the palliation of their disease by experimental methods, can assist the work of the Research Foundation by contacting Dr. Leonard P. Eliel, the Head of the Clinical Cancer Section.

THE JOURNAL
of the
OKLAHOMA STATE MEDICAL ASSOCIATION

EDITORIALS

THE SIXTIETH ANNUAL MEETING IN TULSA

April 13-14-15, '53

Sixty years ago physicians in Oklahoma had much less scientific knowledge to dispense than they have today. But they came together and made plans for an organized effort and an Annual Meeting in order to make what they had available to each other and to the people throughout the State from year to year. It is unfortunate that we cannot literally look back upon that meeting with its small attendance and limited facilities and compare it with the up to the minute meeting which will convene in Tulsa April 13th for a three-day session. Here with all the modern facilities for communication, the best scientific talent of Oklahoma and that of nine distinguished guest speakers will be made available. It is estimated that during the three day session more than 40 scientific lectures will be given. Members of the State Association have only to scan the program appearing in this issue of the *Journal* to see what an opportunity will be afforded at this meeting for profitable post graduate studies. A good attendance is assured and for those who attend a pleasant and profitable sojourn is inevitable.

It is unfortunate that the people of the State cannot see their family physicians in this significant assembly gathering knowledge and skill to be applied at the bedside in their homes. If they only knew that the medical efficiency, the marvelous results of prevention and cure, and the relative freedom from sickness, suffering and pain are due to the sacrificial devotion of their physicians during the past 60 years, they would rise up and fight to the last ditch for the freedom which has made this progress in their behalf a reality.

THE OKLAHOMA DIABETES ASSOCIATION

The members of the State Medical Association know that management is much more important than medicine in the care of their diabetic cases and that education must go hand in hand with management. For this reason all practicing physicians should be interested in the Oklahoma Diabetes Association. This association was organized in 1952. It holds two meetings annually and at each meeting, there is an address by an outstanding guest speaker. Such a meeting will be held April 12 in connection with the State Association. The guest speaker is Garfield G. Duncan, of Philadelphia. All members and guests of the State Association are invited.

Negotiations which will make this Association an affiliate of the National Diabetes Association are now underway. It deserves your support.

THE OKLAHOMA ACADEMY OF GENERAL PRACTICE

The large attendance and the impressive forward looking program at the annual meeting of this promising body having to do with the scientific care of the sick while clinging to the ancient art so important in patient-physician relationship, brings to the people and the profession a new hope.

There is a growing demand for straightforward, sympathetic medicine at the bedside. There is a great need of mutual understanding between patient and physician. Frank discussions of the patient's medical problems on his own intellectual level are highly desirable. Often medical fees and hospital costs weigh heavily on the patient's mind. These factors must be considered in the physician's attempt to clear all psychological conflicts. All the above considerations are necessary to courageously launch the patient on a confident, hopeful course toward recovery. Those physicians who believe medical progress has surpassed patient comprehension should at least give their patients the benefit of the doubt and profit by their appreciation.

Thus the general practitioner may brush away the cobwebs obscuring the patient-physician relationship and bring medical care back to the family level where it belongs.

President's Page

"BEYOND THE ALPS LIES ITALY"

That was the poetic title assigned to me by the teacher for my highschool graduation essay. You will agree that it was quite an ambitious assignment for a boy who scarcely knew his way to the county seat, let alone Italy.

As schoolboys or Medical Associations begin to scale the Alps, and perhaps have succeeded in reaching the top of a small hill or two, the new elevation only serves to bring into view formidable peaks that were not even visible before we began the ascent.

Medicine has made definite progress toward the Elysian fields, but many jagged cliffs yet intervene. We have only reached the first bench of some of them, while others we have not even attempted to clim. They are specifically:

1. Treacherous public relations.
2. "Let George do it" attitude.
3. Professional witnesses, shysters, cults.
4. Public health, preventive medicine.
5. Medical education, medical school, interns, etc.
6. Post graduate education.
7. Distribution of physicians.
8. The narcotics problem.
9. Inequities in industrial medicine and insurance.
10. Blue Cross and Blue Shield.
11. Retirement plan for our employees.
12. Plans for our own building, and in general, a lack of vision, imagination and initiative.

If we ever expect to get to Italy, we better climb.

You have all been wonderful to me this year. Please do even better for Doctor McDonald. My most sincere thanks to each of you for your help.

You have let me pitch for 12 innings, now I am willing to pigtail.

Alfred R Snuggs

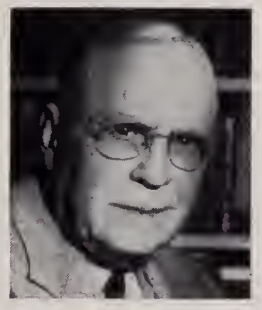
President

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Tulsa
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Sixtieth Annual Meeting

CIMARRON BALLROOM TULSA, OKLAHOMA

April 13-15, 1953

COUNCIL

District No. 1: Craig, Delaware, Mayes, Nowata, Ottawa, Rogers, Washington.

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Vice-Councilor (1953) .....J. E. Highland, M.D., Miami

District No. 2: Kay, Noble, Osage, Pawnee, Payne.

Councilor (1954) .....Clifford Bassett, M.D., Cushing
Vice-Councilor (1954) .....E. C. Mohler, M.D., Ponca City

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Councilor (1955) .....Bruce Hinson, M.D., Enid
Vice-Councilor (1955) .....C. M. Hodgson, M.D., Kingfisher

District No. 4: Alfalfa, Beaver, Cimarron, Ellis, Harper, Major, Texas, Woods, Woodward.

Councilor (1953) .....
Vice-Councilor (1953) .....L. R. Kirby, M.D., Cherokee

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Councilor (1954) .....A. L. Johnson, M.D., El Reno
Vice-Councilor (1954) .....Ross Deputy, M.D., Clinton

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Councilor (1955) .....R. Q. Goodwin, M.D., Oklahoma City
Vice-Councilor (1955) .....Allen Gibbs, M.D., Oklahoma City

District No. 7: Cleveland, Creek, Lincoln, Okfuskee, Pottawatomie, Seminole.

Councilor (1953) .....W. T. Mayfield, M.D., Norman
Vice-Councilor (1953) .....Paul Gallaher, M.D., Shawnee

District No. 8: Tulsa.

Councilor (1954) .....Wilkie Hoover, M.D., Tulsa
Vice-Councilor (1954) .....W. A. Showman, M.D., Tulsa

District No. 9: Adair, Cherokee, McIntosh, Muskogee, Okmulgee, Sequoyah, Wagoner.

Councilor (1955) .....F. R. First, Jr., M.D., Checotah
Vice-Councilor (1955) .....I. W. Bollinger, M.D., Henryetta

District No. 10: Haskell, Hughes, Latimer, LeFlore, Pittsburg.

Councilor (1953) .....E. H. Shuller, M.D., McAlester
Vice-Councilor (1953) .....Paul Kernek, M.D., Holdenville

District No. 11: Atoka, Bryan, Choctaw, Coal, McCurtain, Pushmataha.

Councilor (1954) .....A. T. Baker, M.M., Durant
Vice Councilor (1954) .....T. E. Rhea, M.D., Idabel

District No. 12: Carter, Garvin, Johnston, Love, Marshall, McClain, Murray, Pontotoc.

Councilor (1955) .....J. H. Veazey, M.D., Ardmore
Vice-Councilor (1955) .....W. T. Gill, M.D., Ada

District No. 13: Caddo, Comanche, Cotton, Grady, Jefferson, Stephens.

Councilor (1955) .....H. M. McClure, M.D., Chickasha
Vice-Councilor (1955) .....J. B. Miles, M.D., Anadarko

District No. 14: Greer, Harmon, Jackson, Kiowa, Tillman, Washita.

Councilor (1954) .....L. G. Livingston, M.D., Cordell
Vice-Councilor (1954) .....J. B. Hollis, M.D., Mangum

Welcome to Tulsa

Once again it will be the pleasure of the Tulsa County Medical Society to be host to the Oklahoma State Medical Association for its 60th Annual Meeting in Tulsa, April 13-15, 1953. I believe this will be one of the finest state conventions yet to be held and well worthy of attendance.

The scientific program has been most carefully constructed with over 50 papers in all fields of medicine. The imposing list of visiting distinguished guest speakers contains the best known names in American Medicine and few national or state meetings will be able to match this year in prominence. There are special section meetings in Psychiatry and Neurology, Urology, and Industrial Medicine, and the General Session of Monday afternoon, April 13, is designed for obstetricians, gynecologists, and pediatricians. There will also be roundtable luncheons and medical motion pictures each day, an added feature of our scientific program. Many of the specialty medical organizations are meeting in Tulsa on Sunday, April 12, the day preceding the convention, and you are urged to plan to attend these meetings.

On the lighter side, the President's Inaugural Dinner Dance on Tuesday evening, April 14, will be a delightful evening of entertainment and dancing. The Tulsa County Medical Society will be your host at a complimentary social hour at 6:00 P.M., immediately preceding the dinner. Four hours of dancing are planned, and we are fortunate to have secured one of the best known of America's top name dance bands, Ralph Flanagan and His Orchestra. To enable you to secure a maximum of dancing, the usual after-dinner speech has been eliminated and there will be only a brief inaugural ceremony.

The Auxiliary has one of its best programs in years for the pleasure of visiting wives.

For the first time this year the Annual Meeting is being held in the Cimarron Ballroom, a beautiful auditorium located one block from the Mayo Hotel. In addition to meeting rooms, the Ballroom will accommodate 55 commercial exhibits, and I urge you to visit each and every one of these interesting displays of our commercial friends.

We welcome you to Tulsa, April 13-15, and every hospitality will be shown to the convention visitors. We would like to have 1,000 doctors in attendance this year. Won't you help us reach this goal?

Sincerely yours,

JOHN G. MATT, M.D., President
Tulsa County Medical Society

GENERAL INFORMATION

REGISTRATION

General Registration will open Monday, April 13, 1953, at 8:00 A.M. at the Cimarron Ballroom. Members of the House of Delegates may register on Sunday, April 12, 1953, on the Mezzanine of The Mayo beginning at 12:00 Noon. Members are required to present their 1953 membership card in the Oklahoma State Medical Association before registering. Dues for 1953 will not be accepted at the registration desk except from secretaries of county medical societies. Physicians from outside the State of Oklahoma, interns and residents, and members of the military services will be accorded guest privileges.

SCIENTIFIC PROGRAM

The complete scientific program is published in full in this issue of *The Journal.* General sessions will be held each morning and afternoon, Monday and Tuesday, April 13-14, and on Wednesday morning, April 15, at the Cimarron Ballroom. The Section on Neurology and Psychiatry will meet on Monday afternoon, April 13, at the Cimarron Ballroom, and the Section on Urology on Tuesday afternoon, April 14, at the Cimarron Ballroom. A special feature of interest will be a Symposium on Industrial Medicine to be held in the Ivory Room of The Mayo on Wednesday afternoon, April 15. A complete time schedule of these events is to be found in the official printed program.

MEDICAL MOTION PICTURES

Medical and surgical motion pictures, many in color and sound, will be shown each morning, Monday through Wednesday, April 13-15, in the Mezzanine Meeting Room of the Cimarron Ballroom from 9:30 A.M. to 11:30 A.M. A complete listing of these selected films is to be found in the program.

ROUNDTABLE LUNCHEONS

Roundtable luncheons will be held on Tuesday and Wednesday, April 14-15, at 12:15 P.M. in the Crystal Ballroom of The Mayo. Convention visitors will have an opportunity to direct questions to distinguished guest speakers who will be guests at the luncheons. Tickets should be purchased at the registration desk immediately upon registering.

BLUE CROSS-BLUE SHIELD BUFFET LUNCHEON

Convention visitors are invited to be the guests of the Blue Cross-Blue Shield Plans of Oklahoma at a complimentary buffet luncheon on Monday, April 13, in the General offices of the Plan at 315 South Denver. Luncheon will be served from 12:00 Noon to 2:00 P.M. Oklahoma physicians will have the opportunity to inspect the General Offices of the Blue Cross-Blue Shield Plans of Oklahoma and to meet the personnel of the organization. The offices are located in the same building as the Cimarron Ballroom.

COMMERCIAL EXHIBITS

An interesting and important part of the 60th Annual Meeting of the Oklahoma State Medical Association will be the exhibits of 55 firms catering to the medical profession. Visiting doctors are urged to inspect the many products which will be displayed and to learn of the various services offered by many of the exhibiting firms. Exhibits at the 1953 meeting will feature latest pharmaceutical products, surgical and office supplies, x-ray equipment and supplies, nutritional and medicinal foods, therapeutic clothing and shoes, prosthetic appliances, diagnostic and therapeutic equipment, and specialized services. These exhibitors are in large measure responsible for the financial support of the convention and their interest and participation is sincerely appreciated.

HOUSE OF DELEGATES

The House of Delegates of the Oklahoma State Medical Association will meet on Sunday, April 12, 1953, at 1:00 P.M. in the Emerald Room of The Mayo.

COUNCIL

The Council of the Oklahoma State Medical Association will meet on Sunday, April 12, 1953, at 10:00 A.M. in the Emerald Room of the Mayo, and thereafter at the call of the President.

WOMAN'S AUXILIARY

An interesting and entertaining program of activity for wives and daughters of visiting members has been arranged by the Woman's Auxiliary to the Oklahoma State Medical Association. A complete program of Auxiliary events appears in this issue of *The Journal.*

HOTEL RESERVATIONS

Desirable accommodations are available at five of Tulsa's large and attractive hotels. Members planning to attend the 1953 Annual Meeting are urged to write for reservations at once, using the reservation card to be found in the March issue of *The Journal.* Please do not write hotels directly. All reservations are being handled by the Hotels Committee of the Tulsa County Medical Society. Members will receive a confirmation of reservation directly from the hotel. Please state dates desired, time of arrival, time of departure, and type of accommodation. Please indicate three choices of hotels.

TULSA TOUR

Visiting physicians and their wives are invited to inspect the beautiful residential sections of Tulsa during their visit in the City. The beautiful Philbrook Art Center and the Gilcrease Foundation with its famous collection of Indian art offer a special treat to art lovers. At nearby Claremore visitors may inspect the world famous Will Rogers Memorial. Downtown Tulsa stores offer the latest in modern merchandise and the opportunity to visit large theaters, radio and television stations.

OKLAHOMA ARTHRITIS AND RHEUMATISM ASSOCIATION

Sunday, April 12, 1953
Open Parlors, The Mayo, 9:00 A.M.

Guest Speaker: L. Maxwell Lockie, M.D., Professor of Pharmacology, University of Buffalo School of Medicine, Buffalo, N.Y.

OKLAHOMA CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS

Sunday, April 12, 1953
Metropolitan Room, The Mayo, 1:00 P.M.

OKLAHOMA DIABETES ASSOCIATION

Sunday, April 12, 1953
Terrace Room, The Mayo, 6:30 P.M.

Guest Speaker: Garfield G. Duncan, M.D., Professor of Medicine, Jefferson Medical College, Philadelphia, Pennsylvania.

OKLAHOMA SOCIETY OF ANESTHESIOLOGISTS

Sunday, April 12, 1953
Studio Room, The Mayo, 10:00 A.M.

OKLAHOMA SOCIETY OF NEUROLOGISTS AND PSYCHIATRISTS

Sunday, April 12, 1953
French Room, The Mayo, 6:30 P.M.

OKLAHOMA RADIOLOGICAL SOCIETY

Sunday, April 12, 1953
Room B, The Mayo, 3:00 P.M.

Guest Speaker: Wendell G. Scott, M.D., Associate Professor of Radiology, Washington University School of Medicine, St. Louis, Mo.

MEDICAL ASSISTANTS SOCIETY

April 11-12, 1953
Hotel Tulsa

Guest Speaker, Annual Banquet, Saturday, April 11, 1953: Mr. Stephen T. Donohue, Assistant Director, Department of Public Relations, American Medical Association, Chicago, Ill.

OKLAHOMA STATE DERMATOLOGICAL ASSOCIATION

April 12 — 2:00 P.M.

Association will meet at the Tulsa City Clinic, 6th and Cheyenne.

President's Inaugural Dinner-Dance



RALPH FLANAGAN

TUESDAY, APRIL 14, 1953
Crystal Ballroom, The Mayo

6:00 P.M. Social Hour, Rooms W-Z, 16th Floor, The Mayo.
Courtesy, Tulsa County Medical Society.

7:00 P.M. Dinner. Crystal Ballroom, The Mayo.
Musical Selections.
Inaugural Ceremonies. Presentation of the Gavel of Office, Alfred R. Sugg, M.D., Ada, Retiring President.
Response, John E. McDonald, M.D., Tulsa, President, 1953-54.

9:00 P.M. Dancing to the music of Ralph Flanagan and His Orchestra. Until 1:00 A.M.

TICKET INFORMATION

Tickets to the President's Inaugural Dinner Dance will go on sale March 1, 1953, at the offices of the Tulsa County Medical Society, B-9 Medical Arts Building, Tulsa. Price, $6.50 each, including tax. Attendance will be limited to 500 persons, the capacity of the Crystal Ballroom. Members are urged to purchase tickets in advance. Please make checks payable to "Oklahoma State Medical Association." Tickets will also be on sale at the registration desk for as long as they last.

RALPH FLANAGAN AND HIS ORCHESTRA

Billboard Magazine, the Bible of the Music Industry, calls Ralph Flanagan and His Orchestra "America's Number One Band." The former pianist and arranger for Sammy Kaye and Perry Como who soared to overnight success in 1950 with his own band is well deserving of the title. His record sales are now in excess of 4,000,000 annually, exceeded only by the perennial Guy Lombardo. At America's largest ballrooms Flanagan and his group have set new all-time records with a 1952 gross in excess of a half-million dollars. Popular RCA Victor recording star, featured on his own NBC radio program for 44 weeks last year, and frequently seen on television, Ralph Flanagan and His Orchestra will offer an evening of fine entertainment and dancing to Oklahoma doctors and their wives and guests.

PAST-PRESIDENTS BREAKFAST

The Annual Breakfast For Past-Presidents of the Oklahoma State Medical Association will be held Tuesday, April 14, at 8:30 A.M. at The Mayo.

WOMEN PHYSICIANS BREAKFAST

All women physicians in attendance at the 1953 Annual Meeting of the Oklahoma State Medical Association will be the guests of the women physicians of the Tulsa County Medical Society at breakfast on Tuesday, April 14, 1953, at 7:30 A.M., at Bishop's Restaurant, 516 South Main, Tulsa. Reservations should be made by returning the advance card sent to all women physicians of Oklahoma or at the registration desk.

GOLFING

While there will be no organized golf tournament, members wishing to play golf at one of Tulsa's beautiful country clubs may secure guest cards upon application to the registration desk.

Distinguished Guest Speakers



ALLAN P. BLOXSOM, M. D.
Houston, Texas

Clinical Associate Professor of Pediatrics, University of Texas Medical School. Associate Professor of Clinical Pediatrics, Baylor University Medical College. Medical Degree, Johns Hopkins University, 1927. B. A., Rice Institute, 1923. Postgraduate medical training at Vanderbilt University School of Medicine, William Parker Hospital of New York, and Johns Hopkins Hospital (Harriet Lane Home). Diplomate, American Board of Pediatrics. Fellow, American Academy of Pediatrics.



FRANCIS J. BRACELAND, M.D.
Hartford, Connecticut

Psychiatrist-In-Chief, The Institute of Living. Clinical Professor of Psychiatry, Yale University School of Medicine, New Haven, Connecticut. Medical Degree, Jefferson Medical College, 1930. President, American Board of Psychiatry and Neurology. Former Dean, Loyola University School of Medicine, 1940-41. Formerly Chief Psychiarist, United States Navy, 1942-46. Formerly Chief of the Section on Psychiatry, The Mayo Clinic, 1946-51. Fellow, American College of Physicians. Member, American Psychiatric Association.



F. BAYARD CARTER, M.D.
Durham, North Carolina

Professor and Chairman of the Department of Obstetrics & Gynecology, Duke University School of Medicine. Medical Degree, Johns Hopkins University, 1925. B.A. and M.A., Oxford University, England, 1923. Formerly Chief of the Department of Obstetrics & Gynecology, University of Virginia School of Medicine, 1929-31. President-Elect, American Academy of Obstetrics & Gynecology. Member, American Gynecological Association. Member, Southern Surgical Society.



GARFIELD G. DUNCAN, M. D.
Philadelphia, Pennsylvania

Clinical Professor of Medicine, Jefferson Medical College. Medical Degree, McGill University of Medicine, 1923. Associate Editor, Metabolism. Diplomate, American Board of Internal Medicine. Fellow, American College of Physicians. Expert Consultant to the Surgeon-General, United States Army. Author of numerous textbooks in medicine, the most recent being "Diabetes Mellitus—Principles and Treatment," published in 1951. Member, Association of American Physicians.

Distinguished Guest Speakers



PAUL H. HOLINGER, M. D.
Chicago, Illinois

Professor of Bronchoesophagology, University of Illinois School of Medicine. Medical Degree, Northwestern University Medical School, 1933. Assistant, Chevalier Jackson Clinic, 1934-35. Diplomate, American Board of Otolaryngology. Member, American Academy of Ophthalmology and Otolaryngology. Fellow, American College of Chest Physicians. Member, American Association of Thoracic Surgeons. Attending Bronchoscopist, Children's Memorial Hospital and St. Luke's Hospital, Chicago, Ill.



CARL A. MOYER, M. D.
St. Louis, Missouri

Bixby Professor of Surgery, Washington University School of Medicine, Medical Degree, University of Michigan School of Medicine, 1937. A.B., Northern State Teachers College, Marquette, Michigan, 1930. M.S., University of Michigan, 1934. Formerly Dean, Southwestern Medical College, Dallas, Texas. Diplomate, American Board of Surgery. Fellow, American College of Surgeons. Author of numerious surgical papers published in national medical journals.



W. ALTON OCHSNER, M. D.
New Orleans, Louisiana

Professor and Chairman of the Department of Surgery, Tulane University of Louisiana. Medical Degree, Washington University School of Medicine, 1920. Immediate Past President, American College of Surgeons. Formerly President, American Cancer Society. Formerly President, American Association For Thoracic Surgery. Co-Editor, Surgery. Editor, International Surgical Digest. Member of the Founders Group, American Board of Surgery. Member of the Founders Group, American Board of Thoracic Surgery. Associate Editor, Diseases of the Chest.



JAMES C. SARGENT, M. D.
Milwaukee, Wisconsin

Professor and Chairman of the Department of Urology, Marquette University Medical School. Medical Degree, Ohio State University Medical School, 1915. Chairman, Council of National Emergency Medical Service, American Medical Association. Diplomate, American Board of Urology. Member, American Urological Association. Fellow, American College of Surgeons. Captain, United States Navy Medical Corps, Reserve. Member, Association of Genito-Urinary Surgeons. Formerly President, Wisconsin State Medical Association, 1937-38.



WENDELL C. SCOTT, M. D.
St. Louis, Missouri

Associate Professor of Clinical Radiology, Washington University School of Medicine. Medical Degree, Washington University School of Medicine, 1932. Diplomate, American Board of Radiology. Member, American College of Radiology. Carmen Lecturer, Radiological Society of North America. Associate Editor, American Journal of Roentgenology. Captain, United States Naval Medical Corps, Reserve. Associate Radiologist, Barnes Hospital, St. Louis, Mo. Member, Sigma Xi. Consultant in Radiology, United States Veterans Administration.

LIBRARY OF THE

Scientific Program

Monday, April 13, 1953

GENERAL SESSION

Main Meeting Room, Cimarron Ballroom

John E. McDonald, M.D., Tulsa, Chairman

9:00 A.M. ANTIBIOTICS AND TUBERCULOSIS
Frank L. Bradley, M. D., Talihina

9:20 A.M. DIAGNOSTIC METHODS EMPLOYED AND MANAGEMENT OF INDETERMINATE PULMONARY LESIONS
Robert M. Shepard, Jr., M.D., Tulsa

9:40 A.M. DIAGNOSTIC RADIOLOGIC TECHNIQUE
Wendell G. Scott, M.D., St. Louis, Missouri

10:10 A.M. PRACTICAL ASPECTS IN THE MANAGEMENT OF DIABETES
Garfield G. Duncan, M.D., Philadelphia, Pennsylvania

11:10 A.M. SURGERY OF THE HEART AND GREAT VESSELS
W. Alton Ochsner, M.D., New Orleans, Louisiana

BLUE CROSS-BLUE SHIELD COMPLIMENTARY BUFFET LUNCHEON

Serving From 12:00 Noon To 2:00 P.M.

General Offices, Blue Cross-Blue Shield Plans of Oklahoma, 315 South Denver, Tulsa. Enter from West side of Akdar Theater Building.

MEDICAL MOTION PICTURES

Mezzanine Meeting Room, Cimarron Ballroom

9:30 A.M. - 11:30 A.M.

"LIGATION AND STRIPPING TREATMENT OF VARICOSE VEINS"
By H. D. McPheeters, M.D. and Clarence V. Kusz, M.D., Minneapolis, Minnesota. Courtesy Davis & Geck Company.

"SURGICAL TREATMENT OF PRIMARY HYPERTHYROIDISM"
By Frank H. Lahey, M.D., Boston, Massachusetts. Courtesy Davis & Geck Company.

"TRANSTHORACIC VAGOTOMY"
By Philip Thorek, M.D., Chicago, Illinois. Courtesy Dr. Thorek.

"USE OF THE ARTIFICIAL KIDNEY"
By John P. Merrill, M.D., Boston, Massachusetts. Courtesy Davis & Geck Company.

"SURGICAL TREATMENT FOR MASSIVE GASTRIC HEMORRHAGE"
By Philip Thorek, M.D., Chicago, Illinois. Courtesy Dr. Thorek.

Monday, April 13, 1953

GENERAL SESSION

Main Meeting Room, Cimarron Ballroom

John W. Records, M.D., Oklahoma City, Chairman

2:00 P.M. MANAGEMENT OF ECLAMPSIA
B. C. Chatham, M.D., Chickasha

2:20 P.M. PRESENT CONCEPTS OF TREATMENT OF THE PREGNANT WOMAN IN THE LAST TRIMESTER WITH A DEAD FETUS AND RESULTING TOXEMIA
Brunel D. Faris, M.D., Oklahoma City

2:40 P.M. OBSTETRIC DEATHS
F. Bayard Carter, M.D., Durham, North Carolina

3:20 P.M. RESUSCITATION OF THE NEWBORN INFANT
Allan P. Bloxsom, M.D., Houston, Texas

4:00 P.M. CAUSES OF DEATH IN NEWBORN INFANTS
William T. Newsom, M.D., Oklahoma City

4:20 P.M. HYALINE MEMBRANE DISEASE
Paul M. Obert, M.D., Oklahoma City

SECTION ON NEUROLOGY & PSYCHIATRY

Mezzanine Meeting Room, Cimarron Ballroom

Joe E. Tyler, M.D., Tulsa, Chairman

2:00 P.M. EMOTIONAL ASPECTS OF DIABETES MELLITUS
Paul C. Benton, M.D., Tulsa

2:20 P.M. EARLY DETECTION OF THE EMOTIONAL DISORDERS OF OLD AGE
Francis J. Braceland, M.D., Hartford, Connecticut

3:00 P.M. TOXIC ENCEPHALOPATHY RESULTING FROM LOCAL SCALP APPLICATION OF ASTEROL DIHYDROCHLORIDE IN RINGWORM OF THE SCALP
Arnold H. Ungerman, M.D., and Milford S. Ungerman, M.D., Tulsa

3:20 P.M. AN EVALUATION OF THE DIAGNOSIS AND TREATMENT OF LOW BACK PAIN
Averill Stowell, M.D., and Robert A. Hayne, M.D., Tulsa

Tuesday, April 14, 1953

GENERAL SESSION

Main Meeting Room, Cimarron Ballroom

Alfred R. Sugg, M.D., Ada, Chairman

9:00 A.M. THE CLOSED METHOD OF LAUGE-HANSEN FOR TREATMENT OF ANKLE FRACTURES
David C. Ramsey, M.D., Ada

9:20 A.M. RIGID WIRE FIXATION OF FRACTURES IN THE HAND
Howard B. Shorbe, M.D., and William L. Waldrop, M.D., Oklahoma City

9:40 A.M. TREATMENT OF VARICOSE VEINS
John Powers Wolff, M.D., Oklahoma City

10:00 A.M. MIDDLE LIFE AND MENTAL DISEASE
Francis J. Braceland, M.D., Hartford, Connecticut

10:35 A.M. BRONCHOGENIC CARCINOMA
Paul H. Holinger, M.D., Chicago, Illinois

11:20 A.M. RECENT ADVANCES IN THE TREATMENT OF PORTAL HYPERTENSION
W. Alton Ochsner, M.D., New Orleans, Louisiana

12:15 P.M. ROUNDTABLE LUNCHEON. Crystal Ballroom, The Mayo. Bruce Hinson, M.D., Enid, Chairman. Guest Participants: W. Alton Ochsner, M.D., Francis J. Braceland, M.D., Allan P. Bloxsom, M.D., F. Bayard Carter, M.D.

MEDICAL MOTION PICTURES

Mezzanine Meeting Room, Cimarron Ballroom

9:30 A.M. — 11:30 A.M.

"PORTACAVAL SHUNT"
By John P. Heaney, M.D., Houston, Texas. Courtesy Davis & Geck Company.

"PNEUMONECTOMY"
By Evarts A. Graham, M.D., St. Louis, Missouri. Courtesy Davis & Geck Company.

"SURGICAL TREATMENT FOR CONGENITAL PYLORIC STENOSIS"
By Philip Thorek, M.D., Chicago, Illinois. Courtesy Dr. Thorek.

"EXCISION OF THYRO-GLOSSAL DUCT CYST"
By Conrad J. Baumgartner, M.D., Beverly Hills, California. Courtesy Davis & Geck Company.

"CLASSICAL CHOLECYSTECTOMY"
By Philip Thorek, M.D., Chicago, Illinois. Courtesy Dr. Thorek.

Tuesday, April 14, 1953

GENERAL SESSION

Main Meeting Room, Cimarron Ballroom

John G. Matt, M.D., Tulsa, Chairman

2:00 P.M. WILMS' TUMOR IN INFANCY AND CHILDHOOD
William M. Benzing, Jr., M.D., Tulsa

2:20 P.M. RADIOACTIVE IODINE 131 IN THE TREATMENT OF HYPERTENSION
Wendell G. Scott, M.D., St. Louis, Missouri

2:40 P.M. RESPIRATORY FAILURE DURING SURGERY
Carl A. Moyer, M.D., St. Louis, Missouri

3:20 P.M. THE USE OF PAN-TRANSFUSION SYSTEM
Allan P. Bloxsom, M.D., Houston, Texas

3:50 P.M. THE RADICAL OPERATIVE TREATMENT OF SQUAMOUS CELL CANCER OF THE CERVIX
F. Bayard Carter, M.D., Durham, North Carolina

4:30 P.M. TOTAL HYSTERECTOMY: SIMPLIFIED TECHNIQUE USING NEW INSTRUMENT
William R. Turnbow, M.D., and Raymond G. Ray, M.D., Tulsa

SECTION ON UROLOGY

Mezzanine Meeting Room, Cimarron Ballroom

Emanuel N. Lubin, M.D., Tulsa, Chairman

2:00 P.M. WAYS OF ENDING THE DANGERS IN TRANSURETHRAL PROSTATECTOMY
Henry S. Browne, M.D., Tulsa

DIAGNOSIS AND TREATMENT OF URINARY TRACT INFECTIONS IN CHILDHOOD
D. D. Albers, M.D., J. N. Lysaught, M.D., and E. H. Kalmon, M. D., Oklahoma City

BLADDER TUMORS: THEIR DIAGNOSIS AND TREATMENT
James C. Sargent, M.D., Milwaukee, Wisconsin

PYELOPLASTY: THE PRICELESS INGREDIENT
Berget H. Bloxsom, M.D., Tulsa

RATIONAL MANAGEMENT OF ACUTE URINARY TRACT INFECTION
William F. Boyer, M.D., Tulsa

PRESIDENT'S INAUGURAL DINNER DANCE

Crystal Ballroom, The Mayo, 6:00 P.M.

Wednesday, April 15, 1953

GENERAL SESSION

Main Meeting Room, Cimarron Ballroom

Malcom E. Phelps, M.D., El Reno, Chairman

9:00 A.M. PAROVARIAN CYSTS
Dixon N. Burns, M.D., Tulsa

9:20 A.M.—THE VALUE OF GASTROSCOPY
Henry Laurens, Jr., M.D. and Ray U. Northrip, M.D., Ada

9:40 A.M. THE USE OF ANTICOAGULANTS IN CORONARY ARTERY DISEASE
Camp S. Huntington, M.D., Bartlesville

10:00 A.M. UROLITHIASIS
James C. Sargent, M.D., Milwaukee, Wisconsin

10:40 A.M. THE TREATMENT OF BURNS: A REVIEW OF THE METHODS OF TREATMENT AND ACCOMPLISHMENTS DURING THE PAST CENTURY
Carl A. Moyer, M.D., St. Louis, Missouri

11:20 A.M. THE SIGNIFICANCE OF DYSPHAGIA OR THE LUMP IN THE THROAT
Paul H. Holinger, M.D., Chicago, Illinois

12:15 P.M. ROUNDTABLE LUNCHEON. Crystal Ballroom, The Mayo. John F. Burton, M.D., Oklahoma City, Chairman. Guest Particiants: James C. Sargent, M.D., Wendell G. Scott, M.D., Paul H. Holinger, M.D., Carl A. Moyer, M.D.

MEDICAL MOTION PICTURES

Mezzanine Meeting Room, Cimarron Ballroom

9:30 A.M. - 11:30 A.M.

"JEJUNOSTOMY"
By Philip Thorek, M.D., Chicago, Illinois. Courtesy Dr. Thorek.

"ABDOMINO-PERINEAL RESECTION FOR CARCINOMA OF THE RECTUM"
By Richard B. Cattell, M.D., Boston, Massachusetts. Courtesy Davis & Geck Company.

"OPERATIVE TREATMENT FOR HIRSCHSPRUNG'S DISEASE"
By Orvar Swenson, M.D., Boston, Massachusetts. Courtesy Davis & Geck Company.

"SPLENECTOMY"
By Philip Thorek, M.D., Chicago, Illinois. Courtesy Dr. Thorek.

"PAROTIDECTOMY"
By Robert A. Wise, M.D., New York, N.Y. Courtesy Davis & Geck Company.

Wednesday, April 15, 1953

A SYMPOSIUM ON INDUSTRIAL MEDICINE

Ivory Room, Mezzanine, The Mayo

F. L. Flack, M.D., Tulsa, Moderator

2:00 P.M. HERNIA IN INDUSTRY

F. L. Flack, M.D., Tulsa

CORONARY ARTERY DISEASE IN INDUSTRIAL MEDICINE

William S. Jacobs, M.D., Tulsa

EVALUATION OF MEDICAL TESTIMONY BEFORE THE OKLAHOMA STATE INDUSTRIAL COMMISSION

Judge Thomas Hieronymous, Oklahoma City, Chairman, Oklahoma State Industrial Commission

THE RELATION OF PRIVATE DOCTORS OF MEDICINE TO INDUSTRY

Keifer D. Davis, M.D., Bartlesville

REHABILITATION OF THE INJURED EMPLOYEE

John C. Dague, M.D., Tulsa

HONORARY MEMBERSHIP

Petition for Honorary Membership has been filed in the Executive Office for the following and the Council recommends its approval by the House of Delegates:

Roscoe C. Baker, M.D. ..... Enid

AMALGAMAMTIONS

The following have made application for amalgamation. All requirements have been met and the petition is in order for presentation to the Council and House of Delegates:

Hughes—Seminole Counties

ASSOCIATE MEMBERSHIP

Petition for Associate Membership has been filed in the Executive Office for the following and the Council recommends its approval by the House of Delegates:

Carl R. Doering, M.D. ..... Norman

LIFE MEMBERSHIP

Petitions for Life Membership have been filed in the Executive Office for the following and the Council recommends their approval by the House of Delegates:

George S. Barber ..... Lawton
William LeRoy Bonnell, M.D. ..... Chickasha
W. L. Cary, M.D. ..... Reydon
Paul Grosshart ..... Tulsa
E. S. Kilpatrick, M.D. ..... Elk City
C. B. McMillan, M.D. ..... Gracemont
O. A. Pierson, M.D. ..... Woodward
W. E. Seba, M.D. ..... Leedey
W. J. Trainor ..... Tulsa
Ernest R. Vahlberg, M.D. ..... Oklahoma City

Woman's Auxiliary to the Oklahoma State Medical Association

Mayo Hotel Tulsa, Oklahoma

April 12-15, 1953



MRS. CHARLES A. SMITH
Norman
President
Woman's Auxiliary
to the
Oklahoma State Medical
Association



MRS. MILLARD L. HENRY
McAlester
President-Elect
Woman's Auxiliary
to the
Oklahoma State Medical
Association



MRS. RALPH B. EUSDEN
Long Beach, Calif.
President
Woman's Auxiliary
to the
American Medical Association



MRS. R. F. STOVER
Miami, Florida
President
Woman's Auxiliary
to the
Southern Medical Association

Convention Committees

Convention Chairman	Mrs. Emry G. Hyatt
Convention Co-Chairman	Mrs. Donald L. Mishler
Headquarters and Registration	Mrs. Milton L. Berg
Credentials	Mrs. Harold White
Information	Mrs. F. T. Gastineau
Hospitality	Mrs. I. H. Nelson
Tickets	Mrs. James C. Peters
Finance	Mrs. Robert M. Shepard, Jr.
Transportation	Mrs. D. L. Garrett
Luncheon	Mrs. George H. Miller
Style Show	Mrs. Lowell L. Stokes
Flowers	Mrs. Joseph Fulcher
Publicity	Mrs. C. G. Stuard
Past Presidents	Mrs. Clinton Gallaher

SUNDAY, APRIL 12, 1953

THEME: Our Goal—A Better World

1:00 P.M. to 3:00 P.M.—Registration, Mezzanine Floor, Mayo Hotel

3:00 P.M. to 5:00 P.M.—Tea—Honoring Mrs. Ralph B. Eusden, President of Woman's Auxiliary to the American Medical Association, Mrs. R. F. Stover, President of Woman's Auxiliary to the Southern Medical Association, State Officers and Visiting Wives of members of the Oklahoma State Medical Association and Guest Speakers. Home of Mrs. Hugh Perry, 2232 East 29th Street. Courtesy of the Woman's Auxiliary to the Tulsa-Creek County Medical Auxiliary.

8:00 P.M.—Executive Board Meeting, Hospitality Room, Mayo Hotel
Mrs. Charles A. Smith, presiding

MONDAY, APRIL 13, 1953

THEME: Our Goal—A Better World

8:30 A.M.—Past President's Breakfast
English Room, Mayo Hotel
Mrs. Clinton Gallaher, Hostess

9:00 A.M. to 4:00 P.M.—Registration, Mezzanine Floor, Mayo Hotel

Information, Mezzanine Floor, Mayo Hotel

9:00 A.M. to 5:00 P.M.—Hospitality Room
Hostess Counties—Kay-Noble, Pittsburg and Ottawa-Craig

10:00 A.M. —General Meeting—Mrs. Charles A. Smith, presiding

Ivory Room, Mezzanine Floor, Mayo, Hotel

All members and visiting physicians' wives welcome

Call to order—Mrs. Charles A. Smith, President of the Woman's Auxiliary to the Oklahoma State Medical Association.

Invocation—Mrs. Joseph W. Kelso, Oklahoma City

Pledge of Loyalty — Mrs. Gordon Livingston, Cordell, Oklahoma

"I pledge my loyalty and devotion to the Woman's Auxiliary to the American Medical Association. I will support its reputation, and ever sustain its high ideals."

Welcome—Mrs. Eric M. White, Tulsa, Oklahoma, President-Elect of Tulsa-Creek County Auxiliary

Greetings — Dr. Alfred R. Sugg, Ada, Okla., President of the Oklahoma State Medical Association

Roll Call by Counties—Mrs. George H. Garrison, Oklahoma City, Secretary-Treasurer of the Woman's Auxiliary to the Oklahoma State Medical Association

Reading and Adoption of the Minutes

Presentation of Pages:

Mrs. Peter A. MacKercher, Ponca City, Okla.

Mrs. W. H. Atkins, Norman, Okla.

Introduction of State Officers, Committee Chairmen, County Presidents and Guests

Presentation of reports of all officers Mrs. Charles A. Smith

Report of Revisions and Resolutions Chairman

Mrs. George H. Garrison, Oklahoma City, Oklahoma

Mrs. Ralph B. Eusden, Long Beach, California, President of the Woman's Auxiliary to the American Medical Association

Report of the Nominating Committee:

Mrs. Millard L. Henry, McAlester, Oklahoma, President-Elect of the Woman's Auxiliary to the Oklahoma State Medical Association

Memorial Service, Mrs. James Stevenson Tulsa, Oklahoma

Music, Mrs. Ollie McBride, Ada, Oklahoma

Announcements, Mrs. Emry G. Hyatt, Convention Chairman

TUESDAY, APRIL 14, 1953

THEME: Our Goal—A Better World

9:00 A.M. to 1:00 P.M. —Registration, Mezzanine Floor, Mayo Hotel

Information, Mezzanine Floor, Mayo Hotel

9:00 A.M. to 5:00 P.M. —Hospitality Room—Washington - Nowata and Muskogee Auxiliaries, Hostess Counties

10:00 A.M. —General Meeting, Mrs. Charles A. Smith, presiding, Ivory Room, Mezzanine Floor, Mayo Hotel

Call to Order, by President

Invocation—Mrs. Edward D. Greenberger, McAlester, Okla.

Report of Credentials — Mrs. Harold White, Tulsa, Oklahoma

Roll Call of Voting Delegates Mrs. George H. Garrison

Dr. John E. McDonald, Tulsa, Oklahoma President-Elect of the Oklahoma State Medical Association

Mrs. R. F. Stover, Miami, Florida, President of the Woman's Auxiliary to the Southern Medical Association

Resolutions—Mrs. George H. Garrison, Oklahoma City, Oklahoma

Unfinished Business

New Business

Election of Officers

Installation of Officers—Mrs. Willis K. West, Oklahoma City Oklahoma, Past President, Woman's Auxiliary to the Oklahoma State Medical Association

Other Business

1:00 P.M. —Luncheon — Style Show by Dorothy's Shop, Crystal Ballroom, Mayo Hotel.

Mrs. Herbert S. Orr, presiding, President, Woman's Auxiliary to the Tulsa-Creek County Medical Auxiliary.

Invocation—Mrs. R. W. Goen, Tulsa

6:00 P.M. to 1:00 A.M. —Annual President's Inaugural Dinner-Dance, Social Hour, Dinner and Dance—16th Floor, Crystal Ball Room, Mayo Hotel. Orchestra, Ralph Flanagan

WEDNESDAY, APRIL 15, 1953

THEME: Our Goal—A Better World

9:00 A.M. —Breakfast—Ivory Room, Mezzanine Floor Mayo Hotel

Post Convention (School of Instruction)

Board Meeting, Mrs. Millard L. Henry, President, presiding

Includes all State Officers, Chairmen of Committees, Council Women, Vice-Council Women, County Presidents, Presidents-Elect, Members and Guests.

Oklahoma State Medical Assistants' Society

ANNUAL MEETING, APRIL 10-11-12, 1953

Hotel Tulsa — **Tulsa, Oklahoma**

FRIDAY, APRIL 10, 1953

8:00 P.M.	Open House—Bill Franklin, Host	Oklahoma Room

SATURDAY, APRIL 11, 1953

8:00 A.M.	Registration	Hotel Tulsa
9:00	Call to Order	Ida Mae Cole
	President, Oklahoma State Medical Assistants Society	
9:05	Invocation	Clarice Carter, Oklahoma City
9:10	Greetings	Alma Hall Shaw, Tulsa, Oklahoma
9:15	Speaker	H. Clay Fiske, Tulsa, Oklahoma
9:45	Business	Ida Mae Cole, President
11:15	Speaker	Alfred R. Sugg, M.D., Ada, Oklahoma President, Okla. State Medical Assoc.
11:40	Recess	
12:00	Luncheon	After 5 Room—Blue Cross & Blue Shield
12:45	Speaker	Miss Velma Neely
	Adjourn to Junior Ball Room	
1:30 P.M.	Roll Call	
1:55	Business Session	
2:15	Election of Officers	
2:30	Musical	Four Scouts & Ukes
2:50	Election announcement	
3:00	Address	W. A. Showman, M.D., Tulsa, Okla. Member, Tulsa County Grievance Committee
3:30	Adjourn	
5:30	Reception	Hospitality Room Tulsa County Medical Service Society
7:00	Dinner	Topaz Room
	Dinner Music	Virginia Hall
7:30	Welcome	Hazel Wade, Program Chairman, Tulsa
7:40	Response	Van S. Parmley, M.D., Mangum, Okla.
	Introduction	Officers, Advisors, Guests
8:00	Speaker	Mr. Stephen T. Donohue Assistant Director Public Relations American Medical Assoc., Chicago, Ill.
9:00	Dance	Toby Young's Orchestra

SUNDAY, APRIL 12, 1953

9:00 A.M.	Invocation	Lucille Swearingen, Bartlesville, Okla.
9:05	Breakfast	After 5 Room
9:45	Speaker	
	Adjourn Junior Ballroom	
10:30	Call to Order	Ida Mae Cole, President, Tulsa
10:45	Installation	
10:55	Address	New President
11:05	Business	Appointments
12:00	Luncheon	After 5 Room
12:45	Open Forum	Arthur Johnson—Springer Clinic
	Medical Credit	Joe Ryan—Glass-Nelson Clinic Ken Wallace—St. John's Hospital
1:15 P.M.	Gifts	
1:30	Studio	
2:50	Adjourn	

Convention Registration Fee $6.00—Not Limited to Members—Guests Welcome.
Fee includes—Saturday Luncheon—Dinner-Dance—Sunday Breakfast & Luncheon.
Guest Dinner Tickets $4.00—Dance guests no charge.
Elizabeth Wallace—Convention Chairman—801 Medical Arts Building, Tulsa, Oklahoma.

MAKE YOUR HOTEL RESERVATIONS NOW

Inhibition of Excess Parasympathetic Stimuli in Peptic Ulcer with Banthine®

Medical literature now contains more than 200 references to the beneficial role of Banthine Bromide (brand of methantheline bromide) as evidenced by a marked healing response of peptic ulcers. Rapid symptomatic improvement, particularly with reference to pain relief, is followed by roentgenographic demonstration of crater filling.

The therapeutic action of the drug in decreasing hypermotility and hyperacidity, together with the remarkable early subjective benefit, is indeed a desired approach in ulcer management.

Treatment is individualized to the patient's needs. One or two tablets (50 to 100 mg.) is administered every six hours, around the clock, in conjunction with appropriate diet control and antacid medication as indicated.

Banthine is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. Searle: Research in the Service of Medicine.

Ulcer Facies Composite



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In a review article on hormonal therapy,[1] complete relief of symptoms was reported in 62 per cent of 116 asthma patients. Another 24 per cent were made "quite comfortable." Duration of relief varied widely, with remissions occasionally lasting as long as several months. The author calls these results "truly extraordinary."

[1]Evans, R. R., and Rackemann, F. M.: *A.M.A. Arch. Int. Med.* 90:96–127, July 1952.



Before treatment. Observe typical facies and tense sternocleidomastoid.



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MERCK & CO., INC.
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RAHWAY, NEW JERSEY

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ANNUAL AUDIT REPORT

Alfred R. Sugg, M.D., President
Oklahoma State Medical Association
1227 Classen Drive
Oklahoma City 3, Oklahoma

December 31, 1952

Dear Sir:
We have completed an audit of the financial records of the Membership, Journal, Annual Meeting, History of Medicine, and State Fair Accounts of

THE OKLAHOMA STATE MEDICAL ASSOCIATION
Oklahoma City, Oklahoma

for the period January 1, 1952 to December 31, 1952 and submit the following exhibits herewith:

EXHIBIT "A"—Balance Sheet
EXHIBIT "B"—Income and Expense Statement
EXHIBIT "C"—Schedule of Disbursements
EXHIBIT "D"—Bank Reconciliation

We wish to thank you for this audit.
Please call on us at any time for additional service.

Respectfully submitted,
H. E. COLE COMPANY

OKLAHOMA MEDICAL ASSOCIATION
Oklahoma City, Oklahoma

EXHIBIT "A"

BALANCE SHEET
December 31, 1952

ASSETS

	Total	Membership	Journal	Annual Meeting	History of Medicine	State Fair
CURRENT ASSETS						
Bank	$35,155.05	$33,584.16	$686.53	$622.49	$200.00	$ 61.87
Petty Cash	1.67	1.67	None	None	None	None
TOTAL CURRENT ASSETS	$35,156.72	$33,585.83	$686.53	$622.49	$200.00	$ 61.87
FIXED ASSETS						
Furniture & Fixtures	$ 8,635.21	$ 8,635.21				
Less: Reserve for Depreciation	2,055.84	2,055.84				
TOTAL FIXED ASSETS	$ 6,579.37	$ 6,579.37	None	None	None	None
INVESTMENTS						
U. S. Government Bonds	$12,398.88	$12,398.88	None	None	None	None
TOTAL ASSETS	$54,134.97	$52,564.08	$686.53	$622.49	$200.00	$ 61.87

LIABILITIES

CURRENT LIABILITIES						
Accrued Withholding Tax	$ 366.80	$ 270.10	$ 96.70	None	None	None
Accrued Social Security Tax	19.15	14.19	4.96			
TOTAL CURRENT LIABILITIES	$ 385.95	$ 284.29	$101.66	None	None	None
OPERATING RESERVE	53,749.02	52,279.79	$584.87	$622.49	$200.00	$ 61.87
TOTAL LIABILITIES & CAPITAL	$54,134.97	$52,564.08	$686.53	$622.49	$200.00	$ 61.87

OKLAHOMA STATE MEDICAL ASSOCIATION
Oklahoma City, Oklahoma

EXHIBIT "B"

INCOME & EXPENSE STATEMENT
January 1, 1952 — December 31, 1952

	Total	Membership	Journal	Annual Meeting	History of Medicine	State Fair
Cash Balance	$38,289.99	$36,455.22	$ 1,407.56	$165.34	$200.00	$ 61.87
Petty Cash	29.32	29.32	None	None	None	None
REVENUE						
Ads	$17,200.82		17,200.82			
A.M.A. Commission on Dues	331.94	$ 331.94				
A.M.A.-N.E.M.S. Conference	138.05	138.05				
Booth Space	7,435.00			7,435.00		
Directory Advertising	200.00	200.00				
Dues	58,849.50	58,849.50				
Interest—U.S. Bonds	222.50	222.50				
Journal Copy	1.00		1.00			
Refunds	362.65	362.65				
Rent	600.00	600.00				
Subscriptions	75.85		75.85			
Telephone & Telegraph	162.18	162.18				
Ticket Sales	3,523.00			3,523.00		
Transfer of Funds—Membership	7,000.00		5,000.00	2,000.00		
	$134,421.80	$97,351.36	$23,685.23	$13,123.34	$200.00	$ 61.87

DISBURSEMENTS—Schedule	$99,101.21	$63,676.71	$22,923.65	$12,500.85	None	None
Accruals	385.95	284.29	101.66			
Withholding & Social Security Tax	549.82	373.11	176.71	None	None	None
	$35,156.72	$33,585.83	686.53	$622.49	$200.00	$ 61.87
CASH RECONCILIATION						
Bank Balance 12/31/52	$35,155.05	$33,584.16	686.53	$622.49	$200.00	$ 61.87
Petty Cash 12/31/52	1.67	1.67	None	None	None	None
	$35,156.72	$33,585.83	686.53	$622.49	$200.00	$ 61.87

SCHEDULE OF DISBURSEMENTS — EXHIBIT "C"

December 31, 1952

DISBURSEMENTS	Total	Membership	Journal	Annual Meeting	History of Medicine	State Fair
Annual Meeting Fund	$ 2,000.00	$ 2,000.00				
Annual Meetings:						
Badges	109.26			$109.26		
Committee Expense	116.88			116.88		
Decorating Service	1,715.00			1,715.00		
Entertainment	5,284.13			5,284.13		
Guard & Police Service	89.76			89.76		
Guest Speaker Expense	1,574.27			1,574.27		
Municipal Auditorium	877.00			877.00		
Office Expense	230.12			230.12		
Printing & Publishing	939.33			939.33		
Prospectus—500	63.75			63.75		
Telephone & Telegraph Expense	87.96			87.96		
Television Expense	715.32			715.32		
Y. W. C. A. Luncheon	457.20			457.20		
Equipment—Operator & Miscellaneous Meeting Expense	148.10			148.10		
Orchestra—1953	875.00	875.00				
Invitations—1953	92.77			92.77		
Auditing Expense	375.00	375.00				
Bonding Expense	228.35	228.35				
Blue Cross & Blue Shield	282.70	282.70				
Dues & Associations	147.93	147.93				
Electricity	249.32	249.32				
Insurance	291.75	291.75				
Journal Copies	1,094.64	1.19	1,093.45			
Journal Fund	5,000.00	5,000.00				
Legal Expense	9,184.91	9,184.91				
Meetings & Entertainment	696.66	608.66	88.00			
Office Supplies & Expense	2,197.12	2,197.12				
Oklahoma Industries Tour Expense	469.05	469.05				
Photographs & Certificates	174.62	174.62				
Postage	1,326.94	1,326.94				
Public Policy Account	4,700.00	4,700.00				
Refund of Dues	853.75	853.75				
Repairs—Equipment	103.41	103.41				
Rent	3,300.00	3,300.00				
Safety Deposit Box	6.00	6.00				
Salaries:						
Executive Secretary	10,899.96	10,899.96				
Associate Secretary	5,400.00		5,400.00			
Editor	1,200.00		1,200.00			
Office	11,472.95	8,910.95	2,562.00			
Social Security Expense	289.09	175.88	110.21			
Stationery & Printing	416.83	416.83				
Taxes:						
Federal Employers' Tax	51.93	32.13	19.80			
Oklahoma Employers' Tax	481.55	299.54	182.01			
Property Tax	19.29	19.29				
Telephone & Telegraph Expense	1,809.38	1,809.38				
Texas State Medical Society Exp.	21.21	21.21				
Traveling Expense	7,754.73	7,754.73				
Womens Auxiliary O. S. M. A.	500.00	500.00				
"Hand Grenade"	300.00	300.00				
"Key to Peace"	2.14		2.14			
"History of Medical Science"	7.50		7.50			
Journal:						
Binding Expense	32.00		32.00			
Engraving Expense	373.89		373.89			
Printing Expense	11,686.63		11,686.63			
Press Clippings	113.51		113.51			
50 Year Pin Expense	196.38	161.11	35.27			
Films & Flash Bulbs	17.24		17.24			
TOTAL:	$99,101.21	$63,676.71	$22,923.65	$12,500.85	None	None

OKLAHOMA STATE MEDICAL ASSOCIATION
Oklahoma City, Oklahoma

EXHIBIT "D"

BANK RECONCILIATION
December 31, 1952

MEMBERSHIP FUND			
Liberty National Bank & Trust Company			
Bank Statement Balance 12/31/52			$34,221.03
Less Outstanding Checks			
Voucher	# 4638	$ 67.00	
	# 4686	10.50	
	# 4737	1.00	
	# 4754	33.50	
	# 4831	237.87	
	# 4832	12.00	
	# 4838	275.00	636.87
			$33,584.16
Balance per Books—12/31/52			$33,584.16
JOURNAL FUND			
Liberty National Bank & Trust Company			
Bank Statement Balance 12/31/52			$ 775.73
Less Outstanding Check:			
Voucher	# 4837	89.20	89.20
			$ 686.53
Balance per Books—12/31/52			$ 686.53
ANNUAL MEETING FUND			
Liberty National Bank & Trust Company			
Bank Statement Balance 12/31/52			$ 622.49
Balance Per Books—12/31/52			$ 622.49
HISTORY OF MEDICINE FUND			
Liberty National Bank & Trust Company			
Bank Statement Balance 12/31/52			$ 200.00
Balance per Books—12/31/52			$ 200.00
STATE FAIR FUND			
Liberty National Bank & Trust Company			
Bank Statement Balance 12/31/52			$ 61.87
Balance per Books—12/31/52			$ 61.87

December 31, 1952

Alfred R. Sugg, M.D., President
Oklahoma State Medical Association
1227 Classen Drive
Oklahoma City 3, Oklahoma
Dear Sir:
We have completed examination of the books and records of

THE PUBLIC POLICY ACCOUNT
Of The
OKLAHOMA STATE MEDICAL ASSOCIATION

for the period January 1, 1952 to December 31, 1952, and submit herewith the following exhibits:
EXHIBIT "A"—Balance Sheet
EXHIBIT "B"—Statement of Cash Receipts and Disbursements
We wish to thank you for this audit and the courtesies extended.
Please call on us at any time for additional service.

Respectfully submitted,
H. E. COLE COMPANY

OKLAHOMA STATE MEDICAL ASSOCIATION
Oklahoma City, Oklahoma

EXHIBIT "A"

PUBLIC POLICY ACCOUNT
BALANCE SHEET
December 31, 1952

ASSETS

CURRENT ASSETS		
Cash in Bank		$ 3,609.78
FIXED ASSETS		
Furniture & Fixtures	$ 1,029.54	
Less Reserve for Depreciation	296.54	733.00
TOTAL ASSETS		$ 4,342.78

LIABILITIES

OPERATING RESERVE	$ 4,342.78

OKLAHOMA STATE MEDICAL ASSOCIATION
Oklahoma City, Oklahoma

EXHIBIT "B"

PUBLIC POLICY ACCOUNT
STATEMENT OF CASH RECEIPTS & DISBURSEMENTS
January 1, 1952 — December 31, 1952

Cash Balance—January 1, 1952		$ 1,373.78
REVENUE		
A. M. A. Plaques		192.00
Refund—A. M. A. Students Chicago Trip		28.00
Membership Fund		4,700.00
		$ 6,293.78
DISBURSEMENTS		
A. M. A. Students Chicago Meeting	$ 134.86	
Postage and Express	297.06	
Printing Expense	79.66	
Page Ad—Sooner Medic	90.00	
Telephone and Telegraph	390.96	
Travel Expense	1,052.72	
Meeting Expense	110.66	
"Tell Me Doctor" Expense	482.32	
"To Your Health" Expense	30.00	
"Worth Thinking About" Expense	15.76	$ 2,684.00
BALANCE		$ 3,609.78
CASH RECONCILIATION		
Liberty National Bank & Trust Company		$ 3,609.78

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STATE CHEST PHYSICIANS TO CONVENE IN TULSA

The following program has been announced for the Oklahoma Chapter of the American College of Chest Physicians which will be held in Tulsa at the Mayo Hotel, Sunday April 12:

1:00 p.m.—Business meeting which will consist of formation of the Oklahoma Chapter and election of officers.

2:00 p.m.—R. M. Shepard, Jr., M.D., Tulsa, will present a paper entitled "Management of Pulmonary Emphysema."

3:00 p.m.—Robert R. Shaw, M.D., Dallas, will present a paper, "The Surgery of Acquired Heart Disease."

4:00 p.m.—X-Ray Conference, R. M. Shepard, Sr., M.D., Tulsa, Moderator.

ARTHRITIS ASSOCIATION CONVENTION IS APRIL 12

Members of the Oklahoma State Arthritis Association will meet in Tulsa Sunday, April 12, at the Mayo Hotel for their annual session. Officers are Arthur A. Hellbaum, M.D., Oklahoma City, President; Jack L. Richardson, M.D. Tulsa, President-Elect; J. N. Owens, Jr., M.D., Oklahoma City, Vice-President; and J. R. Ricks, M.D., Oklahoma City, Secretary-Treasurer: Program is as follows:

8:30—Registration
9:00—Board meeting
9:30—Movie
9:45—Anesthesia
Ray Turnbow, M.D.
10:15—X-Rays
Sol Wilner, M.D.
10:45—Orthopedics
Jack Richardson, M.D.
11:15—Guest speaker, L. Maxwell Lockie, M.D., Buffalo, N.Y.
12:15—2:00—Luncheon
2:00—Cardiology as Related to Rheumatology
Tulsa County Heart Association
2:45—Psychosomatic Aspects of Musculoskeletal Diseases
Stewart Wolf, M.D.
3:15—Panel Discussion—Treatment of Arthritis and Rheumatism
A. A. Hellbaum, M.D., Moderator
S. Y. Andelman, M.D., L. Maxwell Lockie, M.D., W. K. Ishmael, M.D., E. Goldfain, M.D., Stewart Wolf, M.D., Members of panel.

DIABETES ASSOCIATION TO MEET APRIL 12

Garfield G. Duncan, M.D., Professor of Medicine, Jefferson Medical School, Philadelphia, is scheduled to speak at the next meeting of the Oklahoma State Diabetes Association April 12 in Tulsa.

The meeting, which will include a social hour, dinner, and Doctor Duncan's address, will begin at 6:30 and will be held at the Mayo Hotel. A charge of $6.00 per person will be made and should be remitted to Earl Mulmed, M.D., 309 Braniff Building, Tulsa, by April 11 so that advance reservations may be made.

Physicians interested in becoming members of the organizations are asked to send their dues in the amount of $3.00 per year to the secretary, Doctor Mulmed. Other officers are: President, Hugh Jeter, M.D., Oklahoma City; and vice-president, Bert F. Keltz, M.D., Oklahoma City. Palmer Howard, M.D., and Richard W. Payne, M.D., both of Oklahoma City, are on the program committee.

A BIG TIME-SAVER FOR EVERY DOCTOR



This handy booklet for new mothers was "built to doctors' orders". It contains blank forms for filling in your instructions and formulas.

It provides a permanent case-history record. A memo will bring you a sample...or as many as you want for your daily practice... without obligation.

Many doctors prescribe "Daricraft Evaporated Milk." It is always uniform, safe, sterilized, easy to digest, and high in food value and minerals. Daricraft contains 400 U. S. P. units of Vitamin D per pint.



Producers Creamery Co., Springfield, Mo.

Commercial Exhibits

Cimarron Ballroom

Exhibitor:

1. Oklahoma Physicians' Supply Company, Oklahoma City, Okla.
2. Raleigh Cigarettes, Brown & Williamson Tobacco Company, Louisville, Ky.
3. Schering Corporation, Bloomfield, N. J.
4. American College of Apothecaries, Oklahoma Chapter, Oklahoma City, Okla.
5. Tattle Toes, Inc., Chesterfield, Mo.
6. Melton-Myers Surgical Supply Company, Tulsa, Okla.
7. Bilhuber-Knoll Corporation, Orange, N. J.
8. H. Dorsey Douglas, Inc., Oklahoma City, Okla.
9. J. E. Hanger, Inc., Oklahoma City, Okla.
11. Dictaphone Corporation, Tulsa, Okla.
14. Chas. Pfizer & Co., Inc., Brooklyn, N. Y.
15. Kool Cigarettes, Brown & Williamson Tobacco Co., Louisville, Ky.
16. J. B. Lippincott & Co., Philadelphia, Pa.
17. Upjohn Company, Kalamazoo, Michigan.
18. A. H. Robins & Company, Richmond, Va.
19. Holland-Rantos Company, New York, N. Y.
20. Baker Audograph Company, Lubbock, Texas.
21. U. S. Vitamin Corporation, New York, N. Y.
22. Lanteen Laboratories, Inc., Evanston, Ill.
23. Merck & Company, Rahway, N.J.
24. S. H. Camp & Company, Jackson, Michigan.
25. Ayerst, McKenna, Harrison, Ltd., New York, N.Y.
26. Mead Johnson Company, Evansville, Indiana.
27. Blue Cross-Blue Shield Plans of Oklahoma, Tulsa, Okla.
28. A. S. Aloe Company, St. Louis, Mo.
29. Travenol Laboratories, Inc., Morton Grove, Ill.
30. General Electric X-Ray Corporation, Tulsa, Okla.
31. Carnation Milk Company, Los Angeles, Calif.
32. Ortho Pharmaceutical Corporation, Raritan, N.J.
33. Doho Chemical Corporation, New York, N.Y.
34. Medco Products, Inc., Tulsa, Okla.
35. Midwest Surgical Supply Corporation, Oklahoma City, Okla.
36. Ciba Pharmaceutical Products, Summit, N.J.
37. Tri-State Pharmaceutical Corporation, Oklahoma City, Okla.
38. M. & R. Laboratories, Inc., Columbus, Ohio.
39. Coca Cola Company, Tulsa, Okla.
41. Chilcott Laboratories, Inc., Morris Plains, N.J.
42. Winthrop-Stearns, Inc., New York, N.Y.
43. Wyeth, Inc., Philadelphia, Pa.
44. Mid-Continent Surgical Supply Company—Merkel X-Ray Corporation, Tulsa, Okla.
45. Philip Morris Tobacco Co., New York, N.Y.
46. J. A. Majors Company, New Orleans, La.
47. Vaisey-Bristol Shoe Company, Rochester, N.Y.
48. United Medical Equipment Company, Kansas City, Mo.
49. National Drug Company, Philadelphia, Pa.
50. E. R. Squibb & Co., New York, N.Y.
51. R. P. Kincheloe Company, Dallas, Texas.
52. Eli Lilly & Company, Indianapolis, Ind.
53. Parke, Davis & Company, Detroit, Mich.
54. Ames Company, Inc., Elkhart, Indiana.
55. G. D. Searle & Company, New York, N.Y.
56. Lederle Laboratories, New York, N.Y.
57. Greb X-Ray Company, Oklahoma City, Okla.

Exhibits Contracted After February 15, 1953, Not Programmed

THE JOURNAL
of the
OKLAHOMA STATE MEDICAL ASSOCIATION

EDITORIALS

MRS. LEE OZBIRN
A Deserving Doctor's Daughter

Mrs. E. Lee Ozbirn, the distinguished daughter of an Oklahoma pioneer doctor, has received many honors because of personal charm, innate ability and outstanding accomplishments. Mrs. Ozbirn, now the Recording Secretary of the General Federation of Women's Clubs, has a long and honorable record of service in this organization, successively occupying many of its important posts. She was a charter member of the Cosmopolitan Club of Sentinel, Oklahoma, and is now an honorary, life member and she is a member of the Twentieth Century Club of Oklahoma City.

Because of her family medical background, she has an abiding interest in health and since the death of her physician brother 18 years ago, she has been active in cancer control. Because of her militant service in this field, she is known as the "Cancer Woman." She is a director of the American Cancer Society and in 1951 received the American Cancer Award in Oklahoma.

Having mentioned only a few of her honors, we now call to the attention of our readers, this most recent preferment in keeping with her medical interests and traditions, namely appointment to the Women's Medical College of Pennsylvania National Board of 100 women leaders. Thus her skills will be exercised and her influence felt at "the center for medical women in this nation."

(See news story in this issue of the *Journal*)

BLUE CROSS - BLUE SHIELD AND THE DOCTOR

The members of the State Association are earnestly requested to give careful consideration to Dr. A. R. Sugg's* recent letter and the enclosed article on the idea of this type of insurance, its meaning to the people and the medical profession and the physician's obligations in connection with its equitable application. Largely, success or failure depends upon the participating physicians.

*Immediate past president of the O.S.M.A.

HUMANISM IN MEDICINE

In this land of ours somewhere between birth and death nearly every individual has occasion to evaluate the services of his physician. The evaluation will not be on a material basis. Though the judgment in each case is individual, the welfare of the profession as a whole is dependent upon the sum total of these evaluations.

Obviously it is important for the physician to make a diagnosis and prescribe the best available treatment. But these functions are on the material side. What of the patient himself; what is he thinking; what is his reaction? Leaving out of consideration the disease which commands medical skills, what rights has the patient as an individual endowed with human needs and human dignity.

Patients are not guinea pigs confined to a pen with a uniform pattern of animal existence. They are human beings with a wide range of intellectual, spiritual and moral gifts. Physicians who disregard these gifts miss the high mark of their profession.

Hippocrates said, ". . . physicians are many in title but very few in reality." No doubt it was this sad truth that prompted him to introduce the Oath and to lay down the following indispensable principles for physicians "learning, sagacity, humanity and probity." It was the humanism of Hippocrates that put medicine on a solid foundation and established the coveted patient-physician relationship.

In modern times magnifying the science of medicine at the expense of the art has established a dangerous trend. When humanism gives way to materialism or when scientific progress usurps the time and thought which should be devoted to the art, the traditional position of medicine in the hearts of the people will be doomed.

It is to be hoped that the American Academy of General Practice while pursuing the science, may realize the great importance of preserving the art. If only this might become the ambition of each of its members, what a high position it would occupy in the realm of organized medicine.

LOFTY PATRIOTISM RETRIEVED

The integrity of the government and government officials means so much to medicine, the *Journal* harks back to the ten commandments laid down by Rabbi Eichler:[1]

"1. Love thy country, which has redeemed thee from tyranny and bondage.

"2. Thou shalt not worship any political idols, nor bow down to them, nor serve them; for their iniquity will be visited on thee and thy children until the third and fourth generation.

"3. Thou shalt not take the name of patriotism in vain, nor use it to hide thy selfish motive.

"4. Remember the day of election, to keep it holy.

"5. Honor the sanctity of the ballot that the days of the Republic may be prolonged.

"6. Thou shalt not kill the spirit of freedom by neglecting to exercise the prerogatives of a freeman.

"7. Thou shalt not adulterate the purity of civic life by entering politics for gain.

"8. Thou shalt not encourage public servants to steal by thy indifference.

"9. Thou shalt not let greed for political reward bear false witness against the spirit of patriotism.

"10. Thou shalt not covet a public office which thou art not fit to fill."

1. World Patriots. John T. M. Johnston. World Patriots Company. Saint Louis. 1917-20-24. Page 297.

THE DECLINE OF MEDICINE IN THE ROMAN EMPIRE — A WARNING

The master medical historian, Max Neuburger, said, "It is noteworthy that the decline of scientific medicine coincided with the epoch in which the interest of the laity in medicine reached its highest point and when participation in medical questions was found in all grades of society."[1]

This statement is accompanied by a long discussion of the medical mysticism in Rome, which had for the time being uprooted the liberal spirit of the Hippocratic teachings and brought about a partial return to the magical and the priestly practices of the art.

In Neuburger's observation, there is "food for thought." The present day popular interest in medicine demands sound methods of lay publicity.

1. History of Medicine. Dr. Max Neuburger. Translated by Ernest Playfair, M.B., M.R.C.P. Vol. I. London. Henry Frowde, Oxford University Press, Hodder and Stoughton, Warwick Square, E. C. 1910. Page 284.

THE "CARDIAC IN INDUSTRY"

In another section of this issue of the *Journal*, the May 5th open meeting of "The Southwest Regional Conference of the National Vocational Rehabilitation Association" is given notice. This conference will be addressed by a distinguished guest, Dr. Leonard J. Goldwater, and should be well attended.

The rehabilitation of the chronic "cardiac" should interest every physician, nurse, public health and social service worker and every citizen in the State. Look for the announcement note, the place, date and the hour and be present if possible.

If William Harvey and William Withering were here, no doubt they would be present. Their shades may be there, at least their influence will appear whether or not they are recognized and properly accredited.

INDIVIDUAL CARE FOR RETARDED CHILDREN

A special department for such care has been established at Benedictine Heights Hospital in Guthrie, Oklahoma.

At present provisions are made for children up to six years of age. This newly established service is most commendable. It helps to fill a crying need; and the venture deserves the patronage of the medical profession. The story appears in another section of this issue of the *Journal*. You are urged to read it.

A. M. A.

JUNE 1-5

NEW YORK CITY

Scientific Articles

VOICE THERAPY FOR HOARSE VOICE

JOHN L. BOLAND, JR., PH.D.
OKLAHOMA CITY, OKLAHOMA

The speech pathologist plays an important, and often indispensable, part in the rehabilitation of many patients with hoarse voice and vocal fatigue.

In many cases more efficient ways of producing voice must be learned before the results of medical and surgical treatment can be permanent. In some cases competent voice therapy can make surgery unnecessary.

The need for voice therapy is mentioned often in the voluminous literature on hoarse voice. This need was emphasized at a Voice Pathology Institute held in Cleveland in August of 1952 under the sponsorship of the Cleveland Speech and Hearing Center, the American Cancer Society, and various medical groups in the Cleveland area.

Two of the principal speakers at this Institute were Louis H. Clerk, M.D., a surgeon well known to otolaryngologists, and Georgiana Peacher, Ph.D., speech pathologist at the Temple University School of Medicine.

The many hundreds of physicians, speech therapists, and others who attended the Institute were kept acutely aware of the danger of hoarse voice by the presence of approximately 500 laryngectomized patients from all over the world who had come to Cleveland to hold the "First International Meeting of Laryngectomized Persons."

Most of these laryngectomees had been hoarse for many months, and perhaps years, before they sought competent medical treatment. The laryngectomy may never have been necessary in many cases if the danger sign of hoarseness had been heeded in time.

How Many Persons Are Hoarse?

So recently have the dangers of hoarseness been recognized that no reliable estimates of the incidence of hoarseness could be found in the literature by this writer. It is safe to say, however, that *the number of persons who are being treated for hoarseness is infinitesimal compared to the number of people who need treatment.*

It is probable that many hoarse persons now reading these paragraphs are not aware that they are hoarse. An individual's opinion about his own voice may not be reliable. People who are hoarse often think of their own voices as being "mellow" or "deep and resonant." This can occur because we hear our own voices partly through the vibration of the bones of our chest and head and so our perception of our voice is unique and is different from the perceptions of other listeners. A voice that sounds "mellow" to its owner can sound quite "hoarse" to a physician.

Many mature and conscientious persons regard vocal fatigue and a certain amount of hoarseness as inevitable results of their jobs. Priests and ministers often seem to expect to be quite tired vocally and to have "husky" voices after delivering sermons.

Many hoarse persons, on the other hand, talk about their hoarseness with pride. Cheerleaders, salesmen, hucksters of all kinds often regard hoarseness as indisputable evidence that they do their jobs well and work hard at them. Adolescents often are proud of their hoarseness after a football weekend and regard the hoarseness as a "normal" result of the activities of the weekend.

It is a mistake, however, to associate hoarseness only with salesmen and persons with boisterous and outgoing personalities. Hoarseness is seen just as frequently in persons who are shy, bashful, and withdrawing. Preachers are often hoarse as are teachers, physicians, and lawyers. *Hoarseness is not confined to one personality type.*

How "Hoarse" Is "Hoarse"?

Obvious hoarseness is easy for even the layman to diagnose but it is difficult to diagnose hoarseness in its early stages. *A voice is not either hoarse or not hoarse.* Hoarseness, like other attributes of human behavior, is a relative matter. By listening carefully to the patient's voice and by watching

for small clues in the patient's vocal behavior, the physician can learn to detect hoarseness when it is just beginning. He can learn even to pick out patients who are hoarseness prone.

The obviously hoarse patient is usually speaking at the bottom of his pitch range, his pitch is a monotone, and he uses too much energy in speaking. He gets emphasis into his conversational speech by changing the loudness of his voice rather than the pitch. Excessive tension in the extrinsic throat muscles often can be seen and the patient tires quickly while speaking. This is the gross picture but often the signs are subtle and inconsistent and must be watched carefully.

Some patients complain that they are hoarse only when they talk to certain persons or when they are in certain social situations. Hoarseness may be heard only in one certain pitch or short range of pitches. Sometimes hoarseness is heard only after the patient has been silent a long time; more often the opposite is true—the patient becomes hoarse only after he has been talking for some time.

Most practicing laryngologists are familiar with patients who are hoarseness prone. The vocal behavior of these patients is characterized by obvious excessive tension in the extrinsic throat musculature, the teeth open hardly at all while the patient is speaking, the patient seems to be trying to talk with his mouth closed.

These patients appear to be talking in the back of their throats or down in their chests. They complain of frequent vocal fatigue and this vocal fatigue is often the only presenting symptom. The patient sometimes considers himself to have a hoarse voice although the harsh, rough voice quality comes and goes.

Sometimes the physician is not able to detect the hoarseness and when he points this out, the patient may state that his "voice is clearer today than it has been for some time."

Hoarseness-prone patients succumb to hoarseness readily, however, and often are hoarse after football games, parties, colds, difficult work, or emotional crises. *This group of patients seems most likely to become chronically hoarse and for this reason early diagnosis and treatment is imperative.*

Causes of Hoarseness:

Clerf[8] pointed out recently that "any lesion, any condition . . . that interferes either with the approximation of the cords, the vibratory movement or the tension of one or both vocal cords, will produce voice changes."

This term "any condition" includes, according to Watkyn-Thomas[9] "a little mucus at one end of the scale to carcinoma of the cord at the other."

One way of thinking about this is to remember that *the normal voice pitch is musical*—it vibrates periodically; *a hoarse voice is noisy*—it vibrates aperiodically. As long as the vocal cords approximate and tense normally, they can vibrate periodically. When something interferes with their approximation or tension (nodes, inflammation, cancer, etc.) they become noisy and the resultant atonal quality is called hoarseness.

Even when no vocal lesions can be found, hoarseness is never normal or natural. Some people can talk for hours without vocal fatigue while others become tired and hoarse after a 30 minute conversation. The difference seems to be in the efficiency with which the voice is used. This fact is well known to laryngologists yet is seldom mentioned in the literature.

The etiology for hoarseness may be psychogenic, physiogenic or both. A casual lesion or growth may be found in the thorax, larynx, pharynx, central nervous system or other part of the body; sometimes no lesion or trauma can be found and the hoarseness seems closely related to the emotional problems of the patient.

Douglas[3] includes the known causes of hoarseness under the following six headings:

(a) Intrinsic lesions—this includes infections of all sorts, carcinomas, vocal nodules, neurofibromas, polyps, papillomas, keratoses, hematomas, and contact ulcers.

(b) Extrinsic lesions — produce their symptoms through involvement of the recurrent laryngeal nerve. Included under this heading are intrathoracic pathologies of many kinds.

(c) Central lesions—includes myasthenia gravis, poliomyelitis, etc.

(d) Peripheral lesions—those involving the ninth, tenth, and 11th cranial nerves.

(e) Infectious lesions — tubercular and leutic lesions, etc.

(f) Psychic factors — psychophonia asthenia and conversion hysteria are said to be the two main subdivisions of this group.

It is obvious from the above that the causes of hoarseness are many and varied. Some of these causes have been found to be directly related to vocal abuse and others have only an indirect relation or no relation at all. The need for voice therapy is the most obvious when vocal misuse is evident, so let us look for a minute at the connections between voice-production habits and the lesions and infections cited above.

Ash and Swartz[1] studied 138 patients made hoarse by "polyps, fibromas, singer's and preacher's nodules, angiomas, amyloid tumors, etc.", and concluded that trauma was the basic etiological factor. They write: "in practically every one of our cases there is a specific history of misuse or excess use of the voice, ranging from the acute screeching at a football game to the prolonged daily 'hup, two, three, four' of the drill sergeant."

These writers, incidentally, regard polyps, fibromas, singer's and preacher's nodes, angiomas and amyloid tumors as representing different stages of the same condition and suggest that they all be consolidated under the single term "laryngeal node" or "true-cord node."

Holinger and Johnston[5] recently reported a series of 1197 patients with benign tumors of the larynx. Of these cases 521 had localized polyps of the vocal cords, and more than 500 of these polyps were attached to the phonating edge of the cords; 193 of the 1197 patients had nodules; 32 were diagnosed as having granulomas associated with contact ulcers.

These reporting physicians state, "the influence of vocal abuse as an etiological factor in the development of many of the lesions herein described, particularly the polyps and nodules, was apparent in reviewing the records. In 21 cases previous removal of a polyp has been done elsewhere. It is felt that persistence of faulty speech habits after removal of the polyp may be responsible for its recurrence."

What is the connection, if any, between polyps or nodes and cancer of the larynx?

This question was asked at the Voice Pathology Institute and Doctor Clerf replied: "Although the connection is not a direct one you recall that vocal nodules all seem invariably to occur in a certain location of the larynx, in the middle and anterior thirds; many of your carcinomas, the early ones that you have an opportunity to see, are in that same locality. I would say geographically they occur in the same location. If there is anything to this theory that a previous disease might be the cause of cancer, then I believe it is quite possible a vocal nodule might ultimately become the seat of cancer."

Most students in this field will probably agree that our present knowledge about the causes of hoarseness is relatively vague and inconclusive. It is evident that persons get hoarse and that certain pathologies are frequently found when the larynges of hoarse people are examined. Vocal misuse sometimes seems directly connected with the hoarseness or with the lesion that seems to be causing the hoarseness. Just as frequently, there is no apparent connection between the hoarseness and vocal abuse.

The Treatment of Hoarseness:

Hoarseness deserves much more concern than it now gets from patient and physician.

Prompt and thorough medical examination is indicated for hoarse patients. Orton[6] writes: "I cannot emphasize too strongly the importance of making a thorough examination in any case of hoarseness lasting over a week or two. Hoarseness is such a common symptom that . . . it is frequently summarily dismissed by the patient, and the doctor, as merely a trifling inconvenience."

After an accurate diagnosis has been made and medical and surgical treatment have been considered, the speech pathologist can be consulted. The treatment of hoarseness must often include voice therapy if the treatment hopes to be successful.

Holinger and Johnston[5] considered that "voice correction therapy is essential for individuals with nodules and polyps as well as for those with granulomas associated with contact ulcers."

Clerf has stated that contact ulcer is certainly due to improper voice use. For many years we persisted in removing them, but since the speech therapists have been able to help us, the customary thing is to institute voice therapy."

Peacher[7] carefully studied the treatment of 16 of Doctor Holinger's patients who had had contact ulcer of the larynx. Six of these patients were given voice therapy as part of their treatment; the remaining 10 were giv-

en surgery or long periods of silence, or both, but no voice therapy.

The symptoms in all cases were eliminated in the experimental group; in the control group (patients who had had no voice therapy), six patients suffered a continuance of symptoms and of the ulcer even after silence or surgery, or both.

Peacher believed that continual misuse of the voice was the perpetuating factor in these patients who still had the symptoms and ulcers after surgery, silence, or both. Silence was not used in the treatment of the experimental group. Peacher believes that *"silence is not a necessary part of this training. If the patient uses his voice correctly, the amount of talking need not make a difference."*

The need for voice therapy for persons with nodules, contact ulcers and certain types of benign lesions is relatively well known and understood by most laryngologists. Almost every patient, however, who is hoarse or who is recognized as hoarseness-prone can benefit from voice therapy.

Early and competent voice therapy can often prevent hoarseness from occurring in persons who suffer from vocal fatigue or are hoarseness-prone. Close working relationships between laryngologists and speech pathologists can often provide effective treatment for patients following thyroidectomy, or those who have certain kinds of laryngeal paralyses.

Any patient whose vocal mechanism is temporarily or permanently weakened from any condition can benefit from voice therapy.

What Is Voice Therapy?

Voice therapy should be carefully distinguished from voice training. Voice therapy usually includes a certain amount of voice training but the speech pathologist is not, primarily, a teacher. He is trained to be a *therapist* with all the implications of that term. His training is concerned with the pathologies of the speech, voice, and language functions and with their treatment.

Most important of all, probably, is the fact that he is trained to cooperate with physicians and other members of the healing arts in the treatment of persons with speech, voice, and language disorders. He considers himself a member of a treatment team.

This writer has found the most effective voice therapy to be a combination of voice training, training in relaxation, and counseling. Sometimes only one or two of these components are needed but usually all three must be used, depending on the needs of the individual patient, before good results are seen. Lasting results are usually assured when the patient learns about the close and complex relationship between voice and personality and gains insight into his own emotional needs and the way these needs may be affecting his vocal behavior.

Duncan[4] writes: "medical examination so often reveals no pathological conditions to account for extremely hoarse, harsh, tight voice. Voice often remains an irrational element in behavior. *Training for insight must be added to exercises.*"

How Long a Time Does Voice Therapy Require?

The length of time required varies, of course, with the needs of the individual patient. The speech pathologist often sees a post-bulbar-polio patient for only one or two visits. With only a little instruction such a patient can sometimes learn enough about his own speech and voice to use them with as much effectiveness as his physical condition will allow.

Patients with heart conditions and with lesions such as multiple sclerosis, Parkinson's disease, etc., in which the voice is affected may often be helped by relatively few hours of voice therapy.

Some patients, however, need many months of voice therapy. The experience of this writer is that satisfactory voice therapy for a hoarse patient usually takes at least one month of intensive work (two to three hours a day) or one year of non-intensive therapy (one or two hours a week).

It is evident from this that both the therapist and patient invest large amounts of time and energy in his kind of therapy and that all patients cannot afford the cost of such treatment. The patient must be strongly motivated before he will spend the time and money required.

The success of such relatively long term therapy assumes, moreover, that the patient is flexible enough to learn to change a part of his behavior which is especially emotion freighted. The patient must, of course, have enough intelligence to realize the dangers of being hoarse and to recognize the necessity for the months of hard work. More limited goals must be set for patients with restrict-

ed intelligence or those who can no longer learn efficiently because of senility or other reasons.

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A.M.A. INAUGURAL CEREMONY WILL BE BROADCAST BY ABC

The American Broadcasting Company radio network will carry the inauguration of Dr. Edward J. McCormick of Toledo, Ohio, as President of the American Medical Association on Wednesday night, June 3, it has been announced by A.M.A. headquarters in Chicago.

The inaugural ceremony at the 102nd Annual Session of the A.M.A. in New York City will be heard over more than 300 ABC stations in this country, Alaska and Hawaii. Except for some local variations because of station program schedules, the inauguration will be carried at 10-10:30 P.M. in the Eastern Time Zone and 9-9:30 P.M. in all other time zones.

The actual inaugural ceremony will take place Tuesday night, June 2, in the Hotel Commodore, but it is expected that practically all radio and television time that night will be disrupted by special news and film programs on the coronation of Queen Elizabeth. It therefore will be necessary to transcribe the program for a delayed broadcast on Wednesday night.

Also originating from the A.M.A. New York meeting this year will be the popular "Dr. Christian" radio program, featuring the well known actor, Jean Hersholt. This program, which will be staged and transcribed Tuesday night one hour prior to the inaugural ceremony in the Grand Ballroom of the Hotel Commodore, also will be rebroadcast on Wednesday night. It will be carried by the Columbia Broadcasting System.

All physicians who will not be in New York for the A.M.A. meeting are urged to watch the radio listings in their newspapers for the local broadcasting times of the ABC inaugural program and the CBS "Dr. Christian" show, both on Wednesday night, June 3.

MEET OUR CONTRIBUTORS

John L. Boland, Jr., Ph.D., Oklahoma City, is the author of "Voice Therapy for Hoarse Voice" in this issue of the Journal. Doctor Boland, a speech pathologist, is consultant in speech pathology, Department of Otorhinolaryngology, University of Oklahoma School of Medicine.

Charles E. Green, M.D., Lawton, wrote the "Report of Maternal Mortality, 1951" in the May Journal. Doctor Green, who is Director of Maternal and Child Health, Oklahoma State Department of Health, was graduated from Indiana University School of Medicine in 1952. He served in the army from 1943-46 and was a major when released. Doctor Green served a residency in pediatrics at Children's Hospital, Washington, D. C.

Edward C. Reifenstein, Jr., M.D., Oklahoma City, has an article on "Fireworks Casualties: A Preventable Cause of Damage, Disability and Death" in this issue. Doctor Reifenstein, who is Director of Research, Oklahoma Medical Research Foundation, is well known to Journal readers as his articles "Current Activities at the Oklahoma Medical Research Foundation" appear in the Journal monthly. He is also professor of research medicine, University School of Medicine and member of the medical center, committee, Oklahoma City Chamber of Commerce.

Richard Wyrick, M.D., Oklahoma City, is the author of "Diagnosis of Ocular Headache" in the May Journal. Doctor Wyrick was graduated from the University of Oklahoma School of Medicine in 1949 and served his internship and residency in ophthalmology at University Hospital.

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DIAGNOSIS OF OCULAR HEADACHE

RICHARD WYRICK, M.D.

OKLAHOMA CITY, OKLAHOMA

One of the commonest of all human complaints is headache. The physician, confronted with this complaint, often has a formidable task to determine its cause. There are many easily recognized causes for headache such as: impending febrile illness, hypertension, diabetes, etc., but much more often no apparent cause can be determined, and the history is frequently vague.

The physician, after a brief superficial examination to rule out the easily recognized causes of headache, is often prone to advise the patient to "have his eyes tested." It is widely believed that "eyestrain" is a very common cause of headache. This is, in fact, not the case. Headache, due to "eyestrain," is very uncommonly met in the ophthalmologist's office. Many times, a brief examination on the part of the practitioner can assure him that his patient's headache is not ocular in origin. In this paper, we will attempt to outline the differential diagnosis of ocular headache in a manner in which the general practitioner can easily carry out in his office.

There are five causes of ocular headache: I. "eyestrain," 2. glaucoma, 3. iritis, 4. orbital neuralgia, and 5. ophthalmorhinalgia. Acute, sub-acute, or even chronic ethmoiditis can cause ocular pain, so we will include this condition. We will deal with these five causes in order. In addition, we will discuss other causes of headache.

The term "eyestrain" has no standard definition. Each ophthalmologist is apt to give a separate definition. The ciliary muscle cannot be "strained" as can a peripheral muscle, such as a back or neck muscle. Most ophthalmologists mean by eyestrain, fatigue of the ciliary muscle from prolonged accommodation. Many laymen believe that prolonged or even permanent loss of vision can result from "eyestrain." Actually, a good night's sleep will be sufficient for anyone's ciliary muscle to recover from the fatigue of prolonged accommodation. It is not accommodation, per se, that causes headache. It is the attempt to maintain binocular vision that results in a headache. Difficulty in maintaining binocular vision is caused by anisometropia and muscle imbalance. Anisometropia means a condition in which there is a difference in the refraction in the two eyes. A headache is most likely to occur if this difference is due to astigmatism. The most common muscle imbalance causing eyestrain headache is convergence insufficiency. Hyperphorias and esophorias also occasionally cause headaches. The physician can get a rough estimate as to the state of refraction of each eye by the use of ophthalmoscope. By keeping his own accommodation relaxed (which requires considerable practice), and determining the dioptic point on his ophthalmoscope at which focus on the retina is obtained he can roughly determine if the patient is myopic or hyperopic. If a difference in the focus point between the two eyes is more than two diopters, anisometropia is probably present. It is difficult for the general practitioner to determine if hyperphoria or esophoria is present, but he can readily check for convergence insufficiency. The normal adult should be able to converge on a pencil or finger brought toward his nose to within 10 centimeters of his nose. If he is not able to do this, he has a certain amount of convergence insufficiency. Keep in mind that one-eyed people never have headaches due to eyestrain since there is no attempt at binocular vision.

Historically, the headache of eyestrain begins in the afternoon or evening. Occasionally it begins in the morning, but seldom before 10:00 AM. It is associated with close work, and many times a patient will not have a headache on his day off. If the headache begins upon arising in the morning, eyestrain is immediately ruled out.

Glaucoma is divided into three categories:

primary acute glaucoma, simple glaucoma, and secondary glaucoma. Primary acute glaucoma is comparatively simple to recognize, for it is almost always congestive. The vision in the affected eye is markedly diminished and the pain is severe, but not necessarily localized to the eye. These patients often have extreme nausea and vomiting, to the degree that intestinal obstruction has been suspected when glaucoma is the case. The diagnosis depends upon the acute onset, the marked loss of vision, congestion, the severe pain, and the fact that the eye is hard to palpation. The ocular fundus can usually not be seen in this condition due to edema of the cornea and lens.

The history of iritis, injury to the eye, or ocular surgery can usually be elicited in seconary glaucoma. Such a history should immediately direct the attention of the examiner to the possible ocular basis for any discomfort the patient is having.

Chronic simple glaucoma is insidious in its course. Frequently, no history can be obtained of any ocular or visual disorder. If the patient has not consulted an ophthalmologist, his vision probably has not diminished yet. Unfortunately, in chronic simple glaucoma, the peripheral vision is lost before the central visual acuity is affected, so the patient is 70 per cent or 80 per cent blind before he realizes he is going blind. The eye is usually perfectly normal in appearance except that frequently the iris is sluggish in reaction or does not react at all, and is dilated. The pain of chronic simple glaucoma occurs at night after the patient has gone to bed, usually toward dawn, and generally clears up about noon. It will occasionally wake the patient up at night. Occurence of pain at night in this case is due to the fact that blood volume in the body undergoes about a 30 per cent increase overnight due to the fact that the patient is not putting out urine, sweating, or putting out moisture with his breath, quite as much as he is during the daytime. An increase in blood volume also increases the volume of the ocular fluids, increasing the intra-ocular pressure, which results in pain. In ruling out this condition as a cause of headache, the ophthalmoscope and sensitive index fingers are the best instruments. If the physician has a tonometer, the tension will run from 30 to about 45. If he does not have a tonometer, he should compare the patient's intra-ocular tension with his own, using his two index fingers on the sclera just above the cornea while the patient is looking down with his eyes closed. As the physician ballots the eye, the index fingers should rub together and not be separated. With a little practice, the physician can often tell if the intra-ocular tension is elevated. In case of chronic simple glaucoma, cupping of the optic nerve is usually seen. Its presence is pathognomonic.

Iritis is usually accompanied by circumcorneal injection, but can occur in a perfectly white eye. The pain of iritis is centered over the affected eye, but radiates posteriorly. It is present constantly, and gets worse toward evening. Photophobia, diminution of vision, and blurred print are frequently symptoms. The pupil is constricted and reacts very sluggishly to light if at all. The iris, itself, may have a muddy appearance. By using the ophthalmoscope for oblique illumination, often small dust particles (inflammatory cells) can be seen in the normally clear anterior chamber. The diagnosis of iritis in a white eye is, at best, difficult, but the signs are enough at least to point to the ocular origin of the headache.

Orbital neuralgia is a neuralgia of the ophthalmic branch of the fifth nerve. It is invariably unilateral and is a diagnosis of exclusion. It is characterized by the lack of findings. The pain in this condition is periorbital and may come on at any time of the day, lasts from a few minutes to a few hours, and can be severe enough to be incapacitating. The treatment for orbital neuralgia is thiamine chloride, 20 mgm. daily, preferably given hyperdermically. Frequently one-half to one grain of thyroid will also help clear up this condition. The treatment need not be given more than three weeks.

So called ophthalmorhinalgia is actually an allergic condition. Usually a definite rhinitis is present, but the pain of the condition is referred to one or other periorbital regions. It is generally unilateral. In the absence of definite symptoms of hay fever, the finding of pallor, and edema of the nasal mucosa and a high eosinophile count from the nasopharynx is helpful in making this diagnosis. Again, there are no other findings in this condition. Treatment consists of antiallergic measures, antihistamines, etc., astringent nasal solutions, removal of any polyps, and in severe cases, skin testing for the actual allergy. Again, in this condition, thiamine chloride is of some benefit.

Another type of headache that can wake a patient up at night is that due to eth-

moiditis or frontal sinusitis. The pain of ethmoiditis is referred to the periorbital region on the side affected. There is pain on pressure of the globe, severe pain around the eye, and no other findings except that of ethmoiditis. These people frequently awake in the middle of the night with severe pain, more common if polyps are present. This is a vacuum type of headache. The pain of frontal sinusitis is referred directly to the frontal region. The treatment is that of sinusitis.

The most common headache is that due to nervous tension. The history is vague, variable, and occasionally bizarre. It may come on at any time during the day or night, but usually comes on toward evening. It is occasionally severe and can cause the patient some nausea. Frequently, the headache will begin fairly suddenly, last from two to three weeks, then disappear as suddenly as it began. As in all functional disorders, vagueness and variation of the history readily point to the functional basis for the headache.

There is another type of headache that will wake a patient up at night, the so-called histamine or Horner's headache. The symptoms are characteristic and cannot be confused with any other type of headache. The onset is sudden and the pain is unilateral. The patient will notice blurriness of vision, excess lacrimation, excess salivation, and feel a flush. The headache usually disappears in a few minutes to about an hour. Of course, whenever one obtains a history of a headache waking a patient up at night, the possibility of a space consuming intracranial lesion must not be overlooked.

Summary:

We have seen that there are five general causes of ocular headache: eyestrain, glaucoma, iritis, orbital neuralgia, and ophthalmorhinalgia. A rough estimation of the presence of any of these conditions can readily be made by a few simple measures. Other causes of headache around the eyes are: ethmoiditis, frontal sinusitis, and Horner's headache. The general practitioner's office is usually not equipped to make a definite diagnosis of any of these conditions, but the probability of one of them being the cause of a headache, for which no other cause has been found, can often be easily determined by the general practitioner in his office.

REPORT ON MATERNAL MOPTALITY 1951*

CHARLES E. GREEN, M.D.

During the year 1951 in the State of Oklahoma there were 50 deaths involving pregnancy or childbirth. Of these, 27 were white women, 17 were Negroes and 6 were Indians. On receipt of the death certificates in the State Department of Health, the Director of Maternal and Child Hygiene mailed questionnaires to the attendants signing the death certificates. The questionnaires are devised to obtain information on the basis of which future maternal deaths may be prevented. The answers are held absolutely confidential; neither the attendant's name nor the doctor's name ever appears in print. The patient, as well as the doctor, is known only by a number on the questionnaire.

The special committee of the State Medical Association for the study and prevention of maternal mortality received returned questionnaires on a total of 47 of these 50 deaths. Because of delay in obtaining supplementary information for some of the cases and a late return on other questionnaires, this report could not be completed until the fall of 1952.

Twenty-four of the 47 deaths on which questionnaires were returned were considered by the committee to be preventable. Nine were considered non-preventable and on 14 the committee was unable to determine preventability.

Out of the 47 deaths reviewed by the committee 10 were in patients who were delivered by Cesarean section.

In the nine deaths which were judged to be non-preventable the diagnoses were as follows: four of them were due to embolic

*Submitted by the State Medical Association's Committee for the Study and Prevention of Maternal Mortality.

phenomena, one probably uremia, one acute yellow atrophy of the liver, one cardiac, one cerebral vascular accident, and one undetermined. There were two Cesarean sections done in this group and one autopsy.

In the 14 cases in which there was insufficient information in the questionnaire to make an assessment the following table indicates the conditions which were considered the cause of death by the attendant who signed the death certificate. The column heading "Diagnosis confirmed" indicates those in which the committee was able to confirm the diagnosis from information in the questionnaire.

Death Certificate Diagnosis In The "No Assesment" Cases

	Diagnosis Confirmed	Cesarean Section	Autopsy
Postpartum eclampsia	Yes	No	No
Postpartum hemorrhage	No	No	No
"DOA" eclampsia history	No	No	No
"Congenital heart failure"	No	No	No
Probably Anesthetic			
Abruptio placenta, "influenza"	No	Yes	No
Eclampsia	No	No	No
Postpartum hemorrhage	No	Yes	No
Eclampsia, diabetic coma	No	Yes	No
Pulmonary embolus	No	No	No
Neurogenic shock secondary to probable adrenal hemorrhage or anaphylactic reaction	No	Yes	No
Probably Anesthetic			
Coronary thrombosis	No	No	No
Probably Anesthetic			
Depressed heart action, cerebral hemorrhage	No	No	No
Probably Anesthetic			
Abruptio placenta	No	Yes	No
Uremia, C-V-R disease, abortion	No	No	No

For the purpose of the study, pregnancies ending between one and 27 weeks are designated as abortion, 28 to 37 weeks as premature birth, and 38 weeks or more as full term births. According to this classification, in four of the 47 cases studied by the committee the death followed abortion. There were four deaths in the group which followed ectopic pregnancy.

The study outlined in the previous paragraphs of this report represents the honest efforts of the committee to review all maternal deaths in the State during 1951, and where possible to determine the cause of death and to bring this information before the profession of the State as a possible method of helping to further reduce the maternal mortality. The committee feels that when the major causes of maternal death in our State can be brought to light and studied by our physicians, further reduction can be accomplished. This has proved possible in other states to a remarkable degree. It is of first importance in this connection to review the maternal mortality rates in Oklahoma.

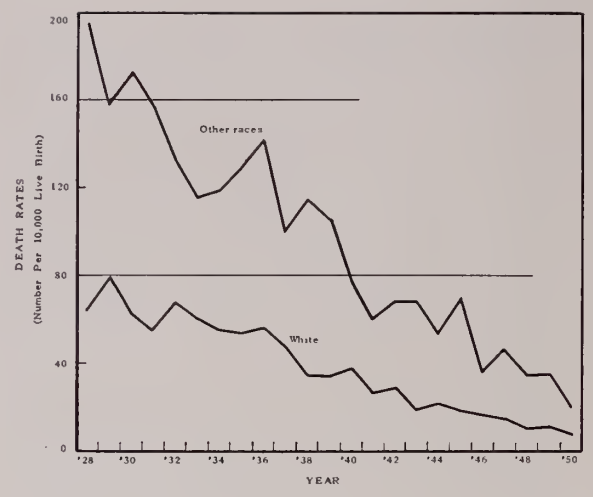
Since 1928 there has been a substantial reduction in deaths in Oklahoma from causes associated with pregnancy, childbirth and the puerperium. During this 23-year period the rates dropped from 71.4 to only 8.5 maternal deaths for every 10,000 live births. The highest number of deaths for any one year was 327 in 1927 compared with only 43 in 1950.*

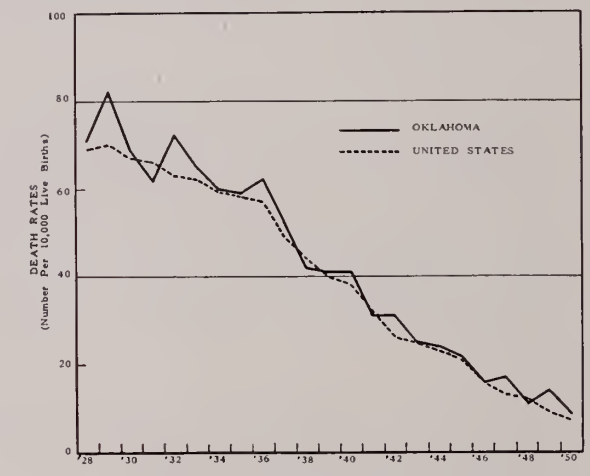
Proportionate decreases since 1928 were very nearly the same for the white as for the Negro and Indian group, 89.0 and 89.5 per cent, respectively. The Negro and Indian races, however, experienced a much greater percentage decrease before 1940 than did the white group—60.3 and 42.2 per cent respectively. These time trends are also shown in Chart 1.

In general, Oklahoma's maternal mortality has continued to be only slightly above the United States average, equalling or falling below it only six times since 1928 (Chart 2). The degree of improvement, however, is practically the same — the United States rate was 89.6 per cent lower in 1950 than in 1928 compared with an 88.0 per cent decrease for Oklahoma.

In addition to the decrease in numbers of maternal deaths, there has been a change in the leading causes of such deaths. Sepsis, which was responsible for almost one-third of the deaths during 1944-1945, was replaced by toxemia which caused more than one-third of the deaths during 1949-1950. Hemorrhage has decreased only slightly. There

*_Maternal, Infant, and Child Mortality, 1928-1950_, Oklahoma State Department of Health, June, 1952, p. 8. Charts in this article are adapted from the same publication, pp. 9 and 10.





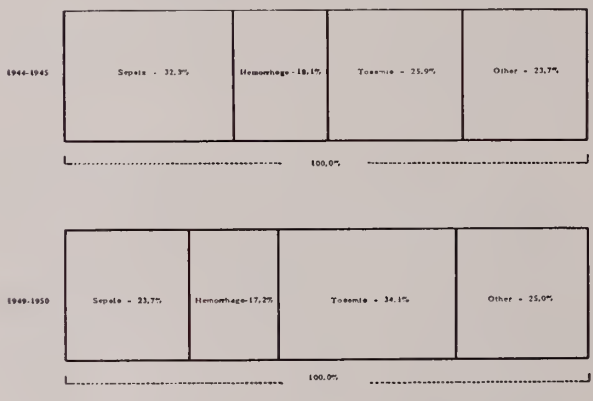


FIG. 1. Maternal Mortality Rates, White and Other Races. Oklahoma, 1928-1950.

FIG. 2. Maternal Mortality Rates. Oklahoma and the United States, 1928-1950.

FIG. 3. Percentage Distribution of Causes of Maternal Deaths. 1944-1945 and 1949-1950.

were no deaths due to sepsis among the 47 studied in 1951. The following figure shows the percentage distribution of these three causes for the two periods.

There are several details concerning the report for 1951 which the committee feels need further comment. It is to be noted that in 14 instances (approximately one in four) the information supplied in the questionnaires returned by the attendants was so completely lacking in clinical details that the committee was unable to determine the sequence of events which led to the maternal death, or to intelligently determine the cause of death. To help to improve this percentage of inadequate reports, the committee is planning to revise the questionnaire to include quite a few more specific questions. It is also to be hoped that those physicians requested to complete a questionnaire in the future will carefully consult their records and give as much pertinent clinical data as possible. By so doing it is anticipated that the number of maternal deaths due to undetermined causes will be reduced to a very minimum.

It is informative to note that in five of the deaths considered by the committee to be preventable, the cause of death was essentially excessive blood loss due to various causes; and in most instances sufficient blood was not replaced to prevent the fatal outcome. These five deaths alone emphasize the great importance of having adequate facilities for rapid blood replacement available in every institution accepting patients for delivery.

It is also to be noted that blood loss in abnormal circumstances of pregnancy and labor should be anticipated and prepared for by the attending physician. Fluids or plasma given intravenously are very poor substitutes for blood and offer only very temporary value, at the most, in the presence of extensive blood loss.

The administration of pituitrin during labor produced rupture of the uterus and death in one proven case and perhaps in others. The committee feels that, although pituitrin may be indicated in some few patients during labor, the attendant must consider the indications, dosage and route of administration very carefully before deciding on its use and if any doubt whatsoever exists concerning the indications that it should not be used. The one death following version and extraction under very poor con-

ditions for such an operative procedure, emphasizes again that this operation is extremely dangerous and very seldom indicated.

Ten deaths followed Cesarean section, but it should be noted that five of these patients are to be found in the group where insufficient data prevented an intelligent estimate of the case. In the five deaths where an estimate could be made the indications were as follows: one eclampsia, one severe toxemia with abruptio, one placenta praevia, one chronic nephritis, polyhydramnios and large baby, and one acute yellow atrophy of the liver).

Nine deaths represent, in general, instances of poor patient cooperation and the failure of the attendant to insist upon hospitalization and the proper obstetrical care until too late in the course of the complications. Much can be done in this group by educational facilities which are already in operation, and by physicians adding their special knowledge and influence with patients in specific instances. The same measures will certainly but gradually operate to reduce the number of deaths (seven in 1951) due to failure of the individual to seek medical care when it is needed and without undue delay.

It is gratifying to note also that no mother died in Oklahoma in 1951 simply because she was unable to pay for her medical and/or hospital care, or because adequate care was not reasonably available.

The following cases were selected by the committee for publication in the *Journal* on the basis of their educational value. Permission of the attendants for the publication has been obtained through the State Department of Health. For obvious reasons, complete anonymity will be maintained. The comments which follow the case histories represent the opinion of the committee and do not necesarily reflect the attitude of the Editors.

CASE NO. 27

The patient was a 35-year-old Negro woman who had six to eight previous children. There was no past history available. Her estimated date of confinement was not stated but she died in the ninth month of pregnancy. She was first seen by the attendant signing the death certificate in her ninth month of pregnancy and she had not had any prenatal care. When first seen she had had six convulsions, her blood pressure was 250/170, and she was in a convulsive state with marked pitting edema and edematous eyegrounds. There was a 4 plus albuminuria.

Before being admitted to the hospital she was attended in the home by an attendant who had attempted to induce labor, using pituitrin and manual dilatation of the cervix. The amount of pituitrin or type was not mentioned and the condition of the cervix was not described. It was stated that this labor had a duration of 14 hours. It was also stated that morphine was used to lessen the labor pains in a dose of one-quarter grain. The patient was in the hospital for one hour before delivery and she was delivered by Cesarean section. It was noted that this procedure required 48 minutes and that the patient died in the operating room. The child was born alive. The indication given for the section was "mother was practically dead but child was still alive."

COMMITTEE'S COMMENTS — In failing to seek prenatal care until the ninth month, the patient should share part of the responsibilty for the death. However, the committee suggested that certain alterations of treatment might have been beneficial after she came under the care of the attendants. The accepted treatment of eclampsia today is not concerned with the question of obstetric interference but is simply a matter of determining the particular form of conservative therapy which is to be employed. Results obtained over a long period of time at many large obstetrical centers in this country attest plainly the danger of radical interference in eclampsia. It has been repeatedly shown that the maternal mortality in eclampsia is increased many times by operative delivery with the patient in a comatose or convulsive state. It has also been shown that the mortality in the severe cases of eclampsia treated by Cesarean section is over four times as high as the mild cases similarly treated. The theoretical reasoning that since eclampsia occurs only in association with pregnancy hence pregnancy must be the cause of the disease, and the best treatment would be to remove the cause as quickly as possible by some rapid means as Cesarean section, has been proven to be fallacious. It has been learned that the trauma inflicted on these sick women by any extensive operative procedure far outweighs any good that may be done.

According to the information furnished in the questionnaire there was little or no treatment directed at the control of the pa-

tient's toxemic manifestations. One exception might have been the quarter grain of morphine which was said to have been given to relieve labor pains. During the two hours she was in the hospital she was given glucose and other medication (unspecified) intravenously. The one hour which elapsed prior to surgery was hardly time enough to evaluate results of any therapy. Both the attendants apparently directed their entire attention to the termination of the pregnancy by medical or operative means.

While it is realized that this patient was in an extreme condition, she apparently was not anuric since a specimen of urine was obtained and she was not in cardiovascular collapse. These facts raised a question as to the imminence of her death. Realizing that this patient may have died regardless of the type of treatment which was used, the committee felt that the preponderance of experience and opinion at the present time would have dictated that this woman receive conservative management.

CASE NO. 71

The patient was a 34-year-old white multipara first seen in the second month of pregnancy and followed adequately through prenatal course with no significant past history. She had had two previous normal pregnancies with normal deliveries at term and one previous miscarriage. She was admitted to the hospital in this pregnancy at term and in early active labor. It was stated that she was having regular uterine contractions and that the membranes had ruptured spontaneously just before admission. During the course of a labor lasting seven to eight hours, a diagnosis of shoulder presentation was made and an internal podalic version was performed under nitrous oxide anesthesia plus curare. Approximately two to three minutes after delivery of a stillborn fetus, by what is termed a moderately difficult version and extraction, the patient went into shock although visible bleeding was not yet evident. Several minutes later excessive bleeding from the vagina occurred. She was given intravenous ergotrate and the uterine packing was instituted. Some delay in obtaining blood was experienced and the patient died in shock with transfusion running, one hour and forty minutes after delivery.

COMMITTEE'S COMMENT—In reviewing this patient's clinical course and death, the committee feels that several points in the management require particular attention.

It seems to the committee that the diagnosis of shoulder presentation should have been suspected and then confirmed either with x-ray or sterile vaginal examination several hours before it was actually determined according to the protocol. Some deviation from the normal clinical course of the patient's labor and especially of the absence of an easily identifiable presenting part should, it seems, have led to an earlier and accurate diagnosis.

The true presentation was actually discovered 7—8 hours after spontaneous rupture of the membranes and onset of labor and it is presumed, although not definitely stated, that the baby was alive and in good condition. These findings should have definitely caused the operator to pause and consider the relative merits of delivery from below with version and extraction or from above by low cervical Casarean section. Certainly at this point in the clinical course the possibilty of hemorrhage with operative delivery from below should have been anticipated and compatible blood obtained before proceeding further.

It is the opinion of the committee that under the circumstances described above the performance of internal podalic version and extraction all too frequently ends in disaster, as it did in this instance. Rupture of the uterus very frequently occurs under these circumstances and it seems almost certain that such was the case in this patient. The committee feels that low cervical Cesarean section would have been a much wiser choice, regardless of the condition of the infant, and that it very likely would have saved the mother and possibly the baby. The risk of infection following section with the present day antibiotics is considered minor when compared with the risk of uterine rupture associated with version and extraction seven to eight hours after rupture of the membranes and onset of labor.

It is stated that the anesthetic used for delivery was "gas and curare." The term "gas" is presumed by the committee to mean nitrous oxide. In this connection it should be noted that deep surgical anesthesia sufficient to relax the uterine musculature is an absolute necessity when performing intrauterine manipulation such as version and extraction. It should also be noted that the effect of curare is predominately on striated muscle and would, therefore, not be expected to add much to uterine relaxation. The committee, therefore, feels that such uterine re-

laxation could not be obtained by nitrous oxide and curare and that this fact should be considered a possible contributing factor to the fatal outcome in this patient.

Finally, according to the protocol it appears that death from hemorrhage occurred too rapidly for the attendant under the circumstances to perform a hysterectomy to stop the bleeding. In such an emergency only heroic efforts in rapidly replacing blood loss and removing the uterus can offer much hope for saving the life of the patient.

The committee feels that this death should be classified as preventable for the reasons stated above.

CASE NO. 37

The patient was a white woman, who had delivered four children living and one dead prior to this pregnancy. The estimated date of confinement was in March. The only past history furnished on the questionnaire was that of the preceding pregnancy which was complicated by placenta previa and severe hemorrhage with delivery being accomplished "manually" at an out-of-state hospital. This was 14 months prior to the patient's death. Recovery following delivery was uneventful. The attendant signing the death certificate stated that she became pregnant again five months later. After about three months she asked for an abortion which, it was stated, was not done because of "family reasons." The attendant stated that he believed that it should have been done and would have done it himself on a charity basis. He also stated that he had advised that her husband be sterilized but this was refused. He did not state his reasons for advising against further pregnancy or sterilization of the husband.

The patient was not examined prior to the day she was delivered. At that time the attendant described some generalized swelling which he felt was insufficient to cause alarm and which he expected to clear up after delivery. The labor was of about three hours duration. One hundred milligrams of demerol were given for relief of labor pains and it was stated to have been the easiest, the most normal labor she ever had. The anesthetic was chloroform and the labor was complicated by hemorrhage which was noted after delivery. The delivery was accomplished at home and two days later she was taken to the hospital. The child was born alive and the patient died five days after being admitted to the hospital. She was taken to the hospital for removal of the placenta which had not been delivered following the baby. There was consultation at the hospital for removal of the placenta. The patient received intravenous glucose and other intravenous medication but no transfusion of blood. She was given sulfathiazole tablets, 12 in number, and penicillin. The attendant stated that although there was some hemorrhage following delivery of the baby it was controlled easily with pituitrin and intravenous vitamins and calcium. She apparently was taken home one day following delivery of the placenta in the hospital and death occurred in the home one week postpartum.

The attendant stated that the patient did not die of hemorrhage although he was certain that it was contributing factor. He apparently felt that the death was due to an acute cardiac decompensation, although he said there were no signs of organic heart disease and that he did not recognize signs of decompensation. He stated that she was weak and "out of breath" for two days following the removal of the placenta and became more dyspneic on the third day. Autopsy was refused by the family. There is no record of any blood count, blood pressure readings or of pulse rate. The temperature reached or exceeded 100.4° for about four hours the night following the delivery of the placenta.

COMMITTEE'S COMMENTS—Based upon the information furnished in the questionnaire, the committee ruled that this was a preventable death. There was no information concerning the patient's prenatal course in the pregnancy but the attendant had seen the patient in about her third month. There were no signs of heart disease at that visit. The patient apparently was guilty of ignorance or neglect in not seeking medical care during her pregnancy.

A patient with retained placenta—even with slight or moderate hemorrhage at the time of delivery—is a patient in potential grave danger and if any hospital facilities are available should not be left at home. The dangers are of course both from hemorrhage and infection. After she was brought to the hospital two days following delivery for removal of the placenta there was no record of her blood picture. Again, a patient who must be subjected to manual removal of the placenta is one who is in grave danger and all means to determine the blood level, with replacement of blood when

it is necessary (and it frequently is) should be made.

It was noted that the patient received intravenous glucose and from this it is deduced that she must have suffered some shock from the procedure. Although intravenous glucose may be of temporary benefit in the treatment of shock following hemorrhage and trauma, it is no substitute for whole blood. It was noted also that she received antibiotics. Although the committee had no means of evaluating the primary cause of death as listed on the certificate of cardiac decompensation, it felt that if there was cardiac damage it might have been aggravated by the effects of hemorrhage and intrauterine infection.

In summary, the committee felt that this death might have been averted by prompt hospitalization when the placenta was found to be retained. Upon hospitalization adequate studies of the blood level prior to manual removal of the placenta and adequate replacement of blood should have been carried out. As long as the patient was not at that time bleeding, prophylactic antibiotics could have been started and administered over at least a 24 hour period prior to the manual extraction. If there was significant bleeding in connection with the extraction blood replacement should have been repeated.

FIREWORKS CASUALITIES: A PREVENTABLE CAUSE OF DAMAGE, DISABILITY AND DEATH

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For a few days each year the promiscuous use of fireworks in many of the states of the United States becomes a major cause of damage by fire, and results in loss of life and much suffering. The purpose of this article is to review this problem and to describe the efforts that have been made in other parts of the country to control it, in order to emphasize the need for legislation in the State of Oklahoma to regulate this source of human accidents and economic loss.

I. The Problem

The use of fireworks for the celebration of public and patriotic events, particularly the observance of Independence Day, has been a tradition in the United States since the birth of the country. The increase in accidents and property damage with the passing years began to arouse public minded citizens about the end of the 19th Century. One of the earliest surveys of the injuries from fireworks and other explosives employed in the celebration of the Fourth-of-July holiday was undertaken in 1903 by the American Medical Association,[1] using hospital reports and newspaper clippings, sources which were admittedly incomplete. During this year, the Association recorded a total of 466 deaths and 3,983 injuries.[2]

During the next six years, the deaths ranged from 158 to 215 and the injuries, from 3,986 to 5,460. In 1910, however, the death total went down to 131 and the injury total to 2,792.

In succeeding years, the decrease was rapid, and in 1916 the American Medical Association survey recorded only 30 deaths and 820 injuries. Because the problem had become relatively small, the Association discontinued its annual survey with the 1916 report.

By 1935 evidence had accumulated indicating that the frequency of these accidents had increased considerably. A detailed study of fireworks injuries was made in this year by the W.P.A., in which newspaper clippings from the entire country were examined during the Fourth-of-July holiday.[3] Reports were accumulated of 7,738 injuries and 30 deaths. A further analysis was made of 3,000 cases. It showed that 800 injuries and

13 deaths were in the one to 10 year age groups, and 797 injuries and six deaths in the 11 to 15 age group. Thus, more than half of the injured were under 15 years of age. Two thirds of the casualties were caused by "firecrackers," 298 by "cherry bombs," 175 by "torpedoes," and 142 by "cannon crackers." "Sparklers" caused four of the deaths.

In 1937 the American Medical Association once again analyzed hospital and newspaper reports[4]. The death total was found to be only 20, but the injury total was 7,205, and it was believed to be incomplete. During the next few years regulative legislation was passed by a number of states, and as a result the number of accidents on a national basis decreased. In 1941 there were only 11 deaths and 2,050 injuries recorded. The survey was not made during the war years, but was repeated in 1946 with the following findings: six deaths and 896 injuries from fireworks and other explosives. The six deaths were described[5] as follows:

"A 13-year-old girl was killed in Philadelphia by an army mortar shell which traveled farther than expected during the celebration. A 17-year-old Milwaukee boy was killed while swimming when a large firecracker was tossed near him. He died as a result of a ruptured lung caused by the explosion. In Louisiana a man died as a result of a gunshot wound in the head. In Beaumont, Texas, a baby died following gas gangrene resulting from a fracture of the right arm. A man in West Virginia received a gunshot wound in the abdomen from which he died. In Paterson, New Jersey, a man, aged 57, died of a heart attack after a prankster had thrown a large firecracker in front of his car. It is noteworthy that none of these fatalities was caused by burns resulting from igniting of clothing from fireworks." These are typical of the reports that have appeared year after year. Of the injuries during 1946, most (792 or 88 per cent) were burns or lacerations. Eye injuries totalled 45, with the loss of an eye in one case. Loss of a finger, hand or other member was recorded in 24 cases; while an internal injury, a fracture, or some other serious accident was recorded in 35 cases.[5]

Unfortunately, national statistics are not available on the property damage that was caused by fireworks during the early part of the 20th Century, and since the passage of anti-fireworks laws in many states beginning about 1935 the amount of economic loss has been reduced considerably. The problem is still one of importance, however, as indicated by a report of the National Board of Fire Underwriters[3] that in the 10 years ending December 31, 1950, there were 3,178 insurance claims due to "fireworks, balloons, etc." (a fire-loss classification). These claims were 0.14 per cent of all claims during this period, and represented a property loss of $1,705,-654.00 or 0.08 per cent of the total insurance losses paid by the insurance companies participating in the National Board of Fire Underwriters.

II. What Has Been Done About the Problem Nationally and in Certain States

Experimentation by communities which were interested in avoiding fireworks casualties by local regulation soon showed that local ordinances could not be completely effective. The hundreds of cities which now prohibit the use of fireworks have found that the distributors erect their stands outside the town boundaries and citizens motor to the border and buy as they please, bootlegging the fireworks back to their homes.[6] The National Fire Protection Association, which had for years advocated a model local ordinance prohibiting fireworks except in a supervised public display, soon realized that the only way such regulation could be fully effective was through state legislation.

The "Model State Fireworks Law" was prepared in 1937-1938 by a special committee of the Fire Marshals' Section of the National Fire Protection Association, and after concurrence of the Committees on Pyrotechnics and Laws and Ordinances was obtained, it was adopted by the NFPA at the 1938 annual meeting. The model was patterned on laws in Iowa, Michigan and New Jersey, the only states at that time which had adequate fireworks control legislation.

In 1949 the National Fire Protection Association adopted a report of the Committee on Pyrotechnics amending the definition of "fireworks" so as to include no longer certain toy paper caps and devices for using them. This was consistent with the practice of the Interstate Commerce Commission and with the fireworks control laws which had proven satisfactory in several states.

In the "Model State Fireworks Law" there are provisions for licensed public display of fireworks, with a minimum bond requirement of $500.00. In the foreword to the "Model Law" it is recommended that, if necessary, the bond should be increased by the local authorities until it is adequate in

their judgment to meet the hazard posed by the proposed public display.

As of 1952, 32 states had adopted legislation regulating or prohibiting the sale and/or use of fireworks.[7] These states are:[8] Alabama, Arizona, Connecticut, Delaware, Florida, Idaho, Illinois, Indiana, Iowa, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Pennsylvania, Rhode Island, South Carolina, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin. In addition, the National Board of Fire Underwriters has developed a "Model Fire Prevention Ordinance" which includes a section regulating pyrotechnics. This law has been adopted by at least 500 cities throughout the country.[3] A revision (Connecticut H.R. 11) modeled on the NFPA code has been proposed recently for the connecticut law by State Representative Stanley F. Withe.[3]

The value of proper fireworks control legislation is today widely recognized as witness the fact that well over half of the national population enjoys the protection of the "Model State Fireworks Law." There is widespread approval for such legislation from many groups,[9] and in various parts of the country support has come from national and state conservation groups, the League of Women Voters, the Federation of Women's Clubs, Service clubs such as Rotary and Kiwanis, Boy Scouts and Girl Scouts Councils, medical organizations, groups working with and for the blind, fire and police chiefs and their associations, insurance companies, and parent - teachers associations. Specific organizations supporting such legislation include the American Medical Association, the National Optometric Association, the American Association of Workers for the Blind, the American Foundation for the Blind, the American Red Cross, the National Fire Protection Association, the International Association of Chiefs of Police, the National Board of Fire Underwriters, the National Safety Council, the Illinois Society for the Prevention of Blindness, the New Jersey Optometric Association, the Pennsylvania Federation of the Blind, and the Hospital Care Association, Inc. of North Carolina.[10]

The experience in the State of Illinois focuses attention on another phase of the problem.[11] In 1950, Illinois passed laws prohibiting the sale and/or use of dangerous fireworks, except for use in properly supervised public displays. In 1951 there was a total of 266 accidents, with 201 burns, lacerations, wounds, etc.; 9 deaths (8 in children); and 56 eye injuries (including accidents to 18 children whose vision was seriously impaired with eight of them blinded in one eye or losing one eye entirely). Incomplete reports from 1952 indicate that there were at least a total of 216 accidents, with 161 burns, lacerations, wounds, etc.; and 55 eye accidents (including injuries to five children who were blinded in one eye or who lost one eye completely). An investigation of one of the accidents in Chicago on June 8, 1951, provided the answer to the difficulty. On that date three children died and five adults were injured in a fire which was caused by fireworks that were illegally obtained by purchasing by mail from a manufacturer in another state where the sale was legal, and having the fireworks shipped into Illinois by an express agency. Steps are being taken to amend the Illinois State Laws to make it illegal to transport fireworks for use within the state. The addresses of fireworks manufacturers have been readily available, particularly to children through advertisements inserted in comic books and children's magazines.[12] These advertisements frequently include coupons for ordering shipments.

The problems that developed in the State of Illinois prompted Congresswoman Marguerite Stitt Church of that state to introduce a bill[7] into the House of Representatives of the 82nd Congress (H.R. 4528) aimed at stopping the bootlegging of fireworks by putting shippers and carriers on notice that the Federal Government will not tolerate the use of interstate commerce for the purpose of circumventing state law. The bill was reported favorably by the House Judiciary committee and the House Rules committee too late for action by the 82nd Congress. The bill has been reintroduced in the House of Representatives of the 83rd Congress (H.R. 116) by Congresswoman Church, and is now pending before the House Judiciary committee.

III. What the State of Oklahoma Must Do About Fireworks

In the 1946 survey of the American Medical Association, the following statement is made: "Fireworks and firecrackers as a source of death and disfigurement can be still further reduced by the prompt enactment and enforcement of suitable legislation in those states, such as Kansas,[13] Nebraska, *Oklahoma*, and Wisconsin,[14] which

do not now have effective laws and which show evidence of a trend toward increasing numbers of injuries from fireworks." In keeping with this thought, State Senator George R. Miskovsky on February 11, 1953 introduced a bill[15] before the 24th Oklahoma State Legislature (originally Senate Bill 205, now listed as Committee Substitute for Senate Bill 206) to provide the necessary legislation to reduce and prevent fireworks casualties as a cause of damage, disability and death. It is now under consideration by the Senate Public Health committee. Physicians of Oklahoma are urged to use their influence with the members of this committee and with the other legislators to secure the passage of this much needed law to protect the children and the homes of the citizens of their state.

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   North Carolina—1947—Laws, p. 222-223, ch. 210.
   North Dakota—1947—Laws, March 11, p. 277-279, ch. 199.
   1951—Laws, Feb. 26, p. 247, ch. 175.
   Ohio—1941—Laws, March 11, p. 8-9.
   Pennsylvania—1939—Code, title 35, sec. 1272.
   Rhode Island—1942—Laws, March 19, p. 32-34, ch. 1130.
   South Carolina—1947—Laws, April 18, p. 151-153, No. 113.
   Utah—1939—Code, sec. 29A-1-1 to 29A-1-2.
   Vermont—1947—Stat., sec. 8588.
   Virginia—1950—Code, 59-214 to 59-219.
   Washington—1943—Laws, March 19, p. 523-525, ch. 161.
   West Virginia—1949—Code, sec. 2813 (1)-(6).
   Wisconsin—1947—Laws, July 2, p. 628-630, ch. 369.
8. Personal Communication: C. S. Morgan, Assistant General Manager, National Fire Protection Association, Boston, 1952.
10. Herndon, E. M.: Laws Prohibiting Sale of Fireworks, J.A.M.A. 149:778 (June 21) 1952.
11. Personal Communication: Mrs. B. H. Gray, Executive Secretary, Illinois Society for the Prevention of Blindness, 1952.
12. Open Road: The Young Peoples Magazine, 34: pp. 33, 35,37,39,41,43, and 48 (June) 1952.
13. The Governor of Kansas has been quoted in the newspapers as stating that he will suggest the enactment of a fireworks law to the 1953 session of the Legislature.
14. The Wisconsin law was passed in 1947 (8).
15. Personal Communication: George R. Miskovsky, Oklahoma State Senator, 1953.

FILM SUPPLEMENT AVAILABLE

County secretaries are reminded that the fourth supplement to the booklet entitled "Reviews of Medical Motion Pictures" is now available from the Committee on Medical Motion Pictures, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois. It contains all film reviews published in the J.A.M.A. from January to December, 1952.

FOUR STATE PROJECTS APPROVED FOR GRANTS

Division of Hospital Facilities, FSA, reports that as of February 1, 1953, four new projects had been approved for Hill-Burton grants in the State of Oklahoma. The projects are:

Tillman County Health Center, Frederick, total cost of $523,890, including federal contribution of $224,890—to supply 32 additional beds.

Norman Municipal Hospital, Norman, total cost of $524,551, including federal contribution of $224,551—to supply 32 additional beds.

Crippled Childrens Hospital, Oklahoma City, total cost of $703,596, including federal contribution of $50,000.

Mayes County Hospital, Pryor, total cost $459,170, including federal contribution of $209,170—to supply 36 additional beds.

Completed and in operation are 58 projects supplying 2,793 additional beds with a federal contribution of $9,394,803.00. Five projects to supply 300 beds are under construction and nine projects are approved but not under construction and will supply 342 additional beds.

GAMMA GLOBULIN DISTRIBUTION EXPLAINED

An advisory committee of the Oklahoma State Medical Association will be appointed soon to assist the State Health Department in the development of plans in regard to distribution of gamma globulin.

Because of limited processing facilities, gamma globulin has been declared a national resource in short supply, and is now allocated and distributed exclusively by the Office of Defense Mobilization, a branch of the Federal Government.

All gamma globulin, both the type know to control measles and infectious hepatitis and the type now known to be of some use against paralytic polio, will be distributed through state health departments.

The initial allocation distributed around May 1, will be based on 40 cc times the median number of reported cases in each particular state for the five year period ending in 1951.

Total basic allotment for the year will be determined for each state on the basis of 40 cc times the number of reported clinically diagnosed cases during the current year.

State health departments will make available to individual physicians 40 cc of gamma globulin per diagnosed case for inoculations of those who have intimate contact with the clinically diagnosed case. It is estimated this will consume about 20 per cent of the available supply. The remaining major part of gamma globulin for polio will be kept in a national pool to be sent to epidemic areas when the need arises. About 2 million cc are being earmarked for measles and infectious hepatitis.

President's Page

LADIES AND GENTLEMEN OF THE OKLAHOMA STATE MEDICAL ASSOCIATION:

May I express my gratitude to my friends, and members of this Association, for their confidence, and trust, which has been placed in me, as their president.

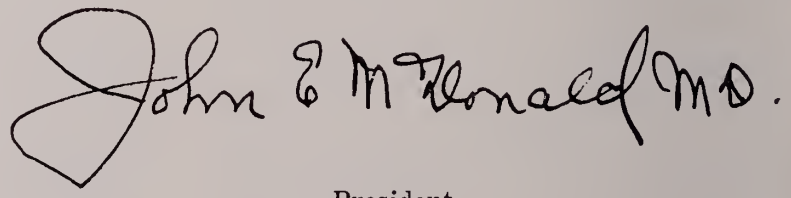
I recognize that it is a service to my association that will require sacrifice of time from my own practice of medicine. I only hope that I am able to discharge this confidence to the satisfaction of the greatest number. It is my fervent desire to hear your wishes, and to meet with you often.

The Public Relations Program of the profession has done much to unveil the shroud of secrecy, and to instill confidence in the public. Much has been accomplished in solving the doctor shortage; and to relieve the economic pressure of the high cost of medical care. Much is yet to be done. The challenge is placed squarely up to the profession. Let us accept it. I shall do my best to afford a humble leadership.

We are indebted to Dr. Alfred R. Sugg, our immediate past president, for a job well done. I, personally, am aware of his sense of duty, even when physical handicap made it extremely difficult. To my friend, Dr. Sugg, may I pay tribute, and hope that I may partially fill his shoes.

I feel as Thomas Jefferson did when he replaced Benjamin Franklin as envoy to France when asked, "Are you to replace Mr. Franklin"? Thomas Jefferson replied, "I am here to relieve him. No one can replace him."

Sincerely,



President



Childhood constipation deserves treatment which gently restores normal peristaltic movements; drastic elimination cannot permanently correct the condition and may be harmful to the child.

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SEARLE Research in the Service of Medicine

SIX PHYSICIANS RECEIVE CERTIFICATES, PINS

In varied ceremonies held from Woodward to Durant, Life Membership certificates have recently been presented to D. W. LeMaster, M.D., Purcell; J. E. Cochran, M.D., Byars; R. D. Cody, M.D., Centrahoma; J. B. Clark, M.D., Coalgate; and 50 Year Pins to O. A. Pierson, M.D., Woodward; Doctor Clark; and Wallace Byrd, M.D., Coagate.

At a meeting of the Cleveland-McClain County Medical Society, the resentations were made to Doctors Cochran and LeMaster by Charles A. Smith, M.D., President of that county society. Doctor LeMaster, who practiced in Tulsa until recently, was graduated from the University of Oklahoma School of Medicine in 1924. Doctor Cochrau was graduated from the University of Tennessee iu 1913.

Doctor Pierson's 50 Year Pin was presented to him by his son, Dwight Pierson, M.D., Mangum at a meeting of the Northwest Oklahoma Medical Society. Doctor Pierson (see picture opposite page) has practiced in Woodward since 1903.

Private presentation ceremonies were held for R. D. Cody, M.D., Centrahoma, and Wallace Byrd, M.D., Coalgate. Doctor Cody, who graduated from Baylor University, came to Centrahoma in 1904. He retired about 10 years ago because of poor health.

Doctor Clark's certificate and pin were presented by A. R. Sugg, M.D. at a meeting of the Atoka-Bryan-Coal Society in Durant. Doctor Clark graduated from Tulane in 1897 and practiced in Dallas, and Corsicana, Texas, before coming to Coalgate, I.T. in 1902.



ABOVE: *John L. Day, M.D., right, receives congratulations from F. E. Flack, M.D.*

FIFTY YEAR PINS, LIFE CERTIFICATES PRESENTED

Alfred R. Sugg of Ada, M.D., President of the Oklahoma State Medical Association, is shown (below left) as he presented Life Membership certificates and 50-Year Club pins to Tulsa physicians at the regu'ar meeting of the Tulsa County Medical Society on February 9, 1953.

Doctor Sugg is pinning a gold 50-Year Club pin on William J. Trainor, M.D., veteran Tulsa cardiologist who will retire from active practice on May 1 after a half-century as a practicing physician. Recipients of Life Membership pictured are, left to right, Daniel L. Perry, M.D., L. C. Presson, M.D., and Robert E. Lee Rhodes, M.D., all of Tulsa, and G. M. Davis, Sr., M.D., Bixby.

A 50-Year Club pin was presented in absentia to P. H. Mayginnes, M.D., Tulsa obstetrician who retired in 1946, and Life Membership certificates to S. S. Mohrman, M.D., Thomas B. Coulter, M.D., Silas Murray, M.D., all of Tulsa, and Richard R. Johnson, M.D., Sand Springs.

BELOW: *A. H. Hathaway, M.D., shakes hands with J. B. Tolbert, M.D., after receiving his certificate.*





OKLAHOMA PHYSICIANS ENTER ACTIVE SERVICE

Eight Oklahoma physicians have recently entered active service according to information received in the Executive Office. They are:

James W. Bayless, Lt. (navy), formerly of Boise City, now aboard ship.

William J. Craig, Lt. (air force), formerly of Oklahoma City.

William J. Dougherty, Lt. (army), formerly of Perry, reported to Fort Sam Houston, San Antonio, Texas.

Leroy Eagles, Capt. (air force), formerly of Durant, reported to Lackland Air Force Base, San Antonio, Texas.

Jack W. Myers, Capt. (air force), formerly of El Reno, assigned to induction center, Oklahoma City.

Carl Osborn, Capt. (army), formerly of Ada, reported to Fort Sam Houston, San Antonio, Texas.

Robert D. Shuttee, Capt. (air force), formerly of Enid, assigned to Tinker Field, Oklahoma City.

Richard J. Schneble, Capt. (army), formerly of Ponca City, assigned to Bremerhaven, Germany.

BENEDICTINE HEIGHTS SETS UP CENTER FOR RETARDED CHILDREN

Oklahoma's first private facilities for the care of mentally retarded children from newborn to five years of age recently opened at Benedictiue Heights Hospital, Guthrie.

Accommodating a maximum of 30 children, Sister Mary Charles, superintendent, pointed out that by limiting the number of children, children could be given more individual attention and a home-like atmosphere in order to encourage and develop their capabilities to the maximum, with emphasis on clothing, feeding and entertaining themselves. The five year age maximum was set because as many of the children reach that age they become "school problems" and the hospital cannot provide an education program.

Maintenance fee of $120.00 per month includes board, room and laundry. Medication charges are extra.



Doctor's Pierson and Mrs. Pierson.

DO YOU KNOW ?

That our Journal deadline is one month before the month of publication? Before you receive your May *Journal*, copy for the June issue had already gone to the printer.

This month we left out "Medical Societies Around the State" because by our May *Journal* deadline (March 31), most of the clippings we had on hand and reports from county society secretaries, our two main sources of information, were dated January. Such information would be more out of date than usual this month because some of it would ordinarily have been used in the April *Journal*. However, that complete issue was devoted to the Annual Meeting program.

County society secretaries are urged, when at all possible, to send reports of their meetings, *before* the meeting instead of after including the time, place, program planned, etc. in the information sent to the Executive Office.

RELEASED FROM SERVICE

Oklahoma physicians recently released from service, according to information received from the Selective Service System are:

Royce Bryan Means, Capt.; Farris Webb Coggins, Capt.; Kenneth L. Wright, Capt.; William G. Husband, Jr., Capt.; William Howard Smith, Capt.; Dayton Morrison Rose, Capt.; Harry T. Avey, Jr., Major; Carl W. Bowie, Capt.; and Charles Brown Cooper, Lt. (JG).

RAIL SCHEDULE TO AMA

For the convenience of Oklahoma physicians planning to attend the A.M.A. in New York June 1-5, the following schedules have been supplied by the Santa Fe. Because of heavy vacation travel at that season of the year, physicians desiring special accommodations are urged to advise their passenger agent well in advance.

Lv. Okla. City .....AT&SF 5:00 A.M. or 5:55 P.M.
Ar. Chicago .....8:00 P.M. or 9:00 A.M.

Lv. Chicago .....Penna. 11:30 P.M., NYC 11.15 P.M.
or Penna. 3:00 P.M., NYC 3:30 P.M.
Ar. New York .....Penna. 5:50 P.M., NYC 6:45 P.M.
or Penna. 8:25 A.M., NYC 9:00 A.M.

RETURN

Lv. New York .....Penna. 5:00 P.M., NYC 5:30 P.M.
or Penna. 11:35 P.M., NYC 11:00 P.M.
Ar. Chicago .....Penna. 8:20 A.M., NYC 9:00 A.M.
or Penna 3:40 P.M., NYC 4:00 P.M.

Lv. Chicago ....AT&SF 9:30 A.M. or AT&SF 6:00 P.M.
Ar. Okla. City AT&SF 12:35 A.M. or AT&SF 8:50 A.M.

The round trip first class fare Oklahoma City to New York is $111.48 plus $16.72 tax, total $128.20. Round trip Pullman fares as follows:

		Total	*Total*
Lower berth	$ 32.70	$ 4.90	$ 37.60
Upper berth	24.80	3.72	28.52
Roomette	45.70	6.86	52.56
Bedroom (for two)	71.90	10.78	82.68
Compartment (for two)	91.40	13.72	105.16
Drawing Room (two or more)	124.20	18.64	142.84

CONFERENCE REPORTS RURAL HEALTH FACILITIES IMPROVED

Medieal care facilities in rural areas are inereasing rapidly through cooperative, voluntary efforts of medical, farm and community groups, it was reported at the eighth National Conference on Rural Health, February 27-28, held in Roanoke, Va.

Oklahomans atteuding the meeting included Dr. and Mrs. R. C. Emmott, Stillwell, Dr. and Mrs. M. H. Newman, Shattuck, David Steen of the Oklahoma Advisory Health Council, and John K. Hart, Associate Executive Secretary of the O.S.M.A.

The 1954 annual rural health conference will be held in Dallas, Texas, Mareh 4-6.

The meeting drew more than 600 representatives of medical, agricultural, university extension services and other groups with a combined membership of several millions. Forty-two states and the District of Columbia were represented at the conference, sponsored by the Council or Rural Health of the American Medical Association.

"All groups are eooperating in an effort to briug the highest standards of medical care to rural areas," Dr. Louis H. Bauer of Hempstead, N.Y., president of the American Medical Association, said. "No one organization cau do the job by itself. It requires a eommunity effort.

"One of the difficulties in the past has been the developing of some means to attract physicians to those regions lacking them. A physician who has spent eight to 13 years of his life in being trained to praetice modern medieine is not willing to settle in an area where there are no facilities for practicing such a type of medieine. Increasing the number of physicians will not do it, as they would still tend to congregate in cities.

"In some states, the problem has been solved by the community providing medical facilities and then permitting the physician to rent those facilities or to buy them through gradual amortization. Where this has been done, physicians have been obtained."

He also pointed out that in these days of good roads and automobiles a physieiau can cover a wider territory than before, and is able to take eare of more people.

"Every eommunity does not need a hospital so long as one is available within a reasonable distanee and good roads lead to it," he added.

A trend away from statism in the solution of rural health problems was reported by Dr. F. S. Crockett of Lafayette, Ind., ehairman of the Council on Rural Health.

Doctor Crockett said that in the planning for adequate medieal care iu small communities a point uppermost has been that "there was to be no Santa Claus in the picture." He reported that group strength has been obtained through the establishment of rural health councils, made up of all facets of community life. These councils, he pointed out, in many instances have brought about the elimination of health hazards and have taught simple health rules to improve conditions.

He stated that sinee 1946 many doctors have settled in villages, adding:

"It is in eommunities on the lower economic income level that the greatest challenge exists. Places with poor schools, churches, roads, homes and farms go hand in hand with inadequate medical care."

Dr. B. N. Saltzman told the meeting he chose praetiee in Mountain Home, Ark., an Ozark mountain town of about 2,000 in preferenee to taking a specialty course in psyehiatry after being discharged from the Army Medical Corps seven years ago.

His suggestions to communities which are in need of a doctor were: (1) let the doctor be invited by organized aetion of eommunity leaders willing to baek up their promises; (2) don't needlessly work the doetor to death; he's human; (3) provide a small eommunity-owned hospital, open to all reputable physieians in the area.

In the last six years, 120 new physieians who were aided finaneially in their education have taken up practice in 77 rural towns in 52 Mississippi eounties, it was pointed out. In addition, 15 scholarship physicians are in military service and another 52 are serving internships, following which they will take up rural praetiee. Two hundred and nine medieal students eurrently are being helped in their sehooling.

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PIONEER PHYSICIAN'S DAUGHTER IS HONORED

A signal honor has come to the daughter of one of Oklahoma's pioneer physicians. Mrs. E. Lee Ozbirn, formerly Katie Freeman, daughter of Wiley Howell Freeman, M.D., has been selected as a member of the National Board of the Woman's Medical College of Pennsylvania, the only woman's Medical College in the western hemisphere. There are 175 students in the college and 30 candidates for the degree. It has a faculty of 219.



Mrs. E. Lee Ozbirn

Mrs. Ozbirn, who is now State Commander of the Oklahoma Division of the American Cancer Society, became interested in cancer control in 1935 following the death of her only brother, who was also a physician. Often called the "Cancer Woman" in Oklahoma, she has given continuous volunteer effort in behalf of cancer control for 17 years.

She is a member of the board of directors of the American Cancer Society and in recognition of her service, received the 1951 American Cancer Award in Oklahoma, the first lay person to receive this recognition in the State.

Mrs. Ozbirn, who is Recording Secretary of the General Federation of Women's Clubs, has been in Federated Club work for 27 years and was a charter member of the Cosmopolitan club of Sentinel. She is also a member of the Twentieth Century club of Oklahoma City. She has served 13 years as a member of the board of directors for the General Federation, three years as a state president, and has held many other offices in the General Federation of Women's Clubs.

She has been listed as one of the five most prominent women in Oklahoma, and in 1952 received a plaque from Quota International Club of Oklahoma City for "outstanding service to her community." She also received the 1952 award certificate from Soroptomist International for outstanding community service and recently was commissioned "Commander of the Oklahoma Navy" by the Governor of Oklahoma.

She is a member of many other fraternal, social and civic organizations.

ANNOUNCEMENTS

AMERICAN MEDICAL ASSOCIATION. June 1-5, New York City.

ROCKY MOUNTAIN CANCER CONFERENCE. July 7-8-9, Denver, Colo. No registration fee. For further information, contact Harvey Sethman, Executive Secretary, Colorado State Medical Society, 835 Republic Bldg., Denver 2, Colo.

AMERICAN GOITER ASSOCIATION. May 7-9, Drake Hotel, Chicago.

INTERNATIONAL ACADEMY OF PROCTOLOGY. May 29-31, Plaza Hotel, New York City. No registration fee. Program available from Executive offices of the International Academy of Proctology, 43-55 Kissena Blvd., Flushing, New York.

ANNUAL ASSEMBLY IN OTOLARYNGOLOGY. University of Illinois College of Medicine basic section September 21-26; clinical section September 28-Oct. 3. Applications may be obtained from the Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk St., Chicago 12, Ill.

TEXAS MEDICAL CENTER. May 15-16, Shamrock Hotel, Houston. Seventh Annual Symposium on Fundamental Cancer Research, Cancer Pathology and Radiology Conference, South Central Section of the College of American Pathologists. Further information may be obtained from William O. Russell, M.D., 2310 Baldwin Street, Houston 6, Texas.

VOCATIONAL REHABILITATION GROUP TO MEET IN OKLAHOMA

An open meeting of the Southwest Regional Conference of the National Vocational Rehabilitation Association will be held at the Huckins Hotel, Oklahoma City, May 5, convening at 10:15 a.m.

Guest speaker will be Leonard J. Goldwater, M.D., Professor of Public Health and Preventive Medicine at Columbia University, New York City, who will speak on employment of the cardiac in industry.

Representatives of Labor, industry, insurance carriers, management and physicians are being invited to attend.



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1. Thorn, G. W., and Tyler, F. H.: *Med. Clin. North America*, 31:1081, Sept. 1947.

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OBITUARIES

O. C. NEWMAN, M. D.
1876-1953

O. C. Newman, M.D., pioneer Oklahoma physician, died March 14, following a long illness.

Doctor Newman was born in Adams County, Ohio, and spent his boyhood on a farm near Peebles, Ohio. Following his graduation from the University of the South in Tennessee, Doctor Newman began practicing in Grand Day county, Oklahoma Territory in 1900.

He moved to Shattuck in 1907 and established his first hospital. His first brick hospital was built in 1924 and in 1927 he built his first hospital that included x-ray, laboratory, etc. Sixteen more rooms were added in 1929. Again in 1937 he enlarged his hospital and in 1947 the hospital and clinic was again doubled in capacity.

Since 1912, Doctor Newman continued active postgraduate work. He spent three to six weeks each year in postgraduate work in addition to yearly visits for observation of surgery at the Mayo Clinic.

Elected to the Hall of Fame in 1943, other positions he held include: member of the Board of Medical Examiners, Councilor of the O.S.M.A., member of the American College of Surgeons, Masonic Lodge, and he had received an O.S.M.A. 50 year pin.

Doctor and Mrs. Newman celebrated their golden wedding anniversary September 18, 1952.

Survivors include his widow and three sons, Doctor M. H., Doctor Roy E., and Doctor Floyd S. Newman, all of Shattuck, one sister, and four grandchildren.

D. D. ROBERTS, M. D.
1877-1953

D. D. Roberts, M.D., long-time Enid physician, died March 2 after a long illness.

Doctor Roberts was born near Hume, Ill., and attended school there. He received his pre-medical education in Kentucky and graduated in 1906 from the University of Louisville college of medicine.

He practiced for many years in Nash and in 1921 moved to Enid. Doctor Roberts was active in church, medical and civic organizations. He was a former president of the Enid Kiwanis club and was a member of the American Legion and a 32nd. degree Mason.

Doctor Roberts is survived by his widow of the home, three daughters, one son, six grandchildren and one brother.

HERBERT L. WRIGHT, M. D.
1872-1953

Herbert L. Wright, M.D., retired Sasakwa physician, died February 12 in a Wewoka hospital, following a 10 year illness.

Doctor Wright had served with the U. S. Public Health Service in Oklahoma, Illinois and Arizona.

A native of Missouri, he is survived by two brothers, Rush L. Wright, M.D., Poteau; and P. E. Wright, M.D., Golconda, Ill.

JULIUS WILLIAM NIEWEG, M. D.
1869-1953

Julius William Nieweg, M.D., who opened his medical practice in Duncan in 1909, was born at Lanes Prairie, Mo., April 20, 1869. He practiced medicine for 26 years in Duncan and for 22 years in Missouri before coming to Duncan.

He was active in church work and was a Deacon in the Baptist church.

Survivors are the widow and several nieces and nephews.

H. C. Manning, M. D.
1880-1953

Homer C. Manning, M.D., long-time Cushing physician, died suddenly at his home, February 8, 1953. He had been in poor health for the past two years.

Doctor Manning graduated from Grant University of Chattanooga, Tennessee, in 1907. He came to Oklahoma Territory in 1907, first locating at Davenport. Later that year he bought out the practice of P. H. McGinnis and moved to Cushing.

Doctor Manning was born in Kentucky on April 1, 1880. He was active in all local medical activities as long as his health would permit. He operated the Cushing Hospital for a number of years. Dr. Manning was president of the Payne County Medical Society several times, and vice president of the American Association of Railway Surgeons in 1924. He was a charter member of the Cushing Masonic Lodge and was a Royal Arch and 32nd Degree Mason.

Survivors include the widow of the home, one son, Joe, of Cushing, and one grandson.

RESOLUTION

WHEREAS, Our Heavenly Father has seen fit to remove from our midst our beloved member, W. A. Tolleson, M.D. of Eufaula, Oklahoma, and

WHEREAS, by the death of W. A. Tolleson, M.D., the East Central Oklahoma Medical Society, the staff of the Oklahoma Baptist Hospital, and those who have been under his medical care and depended upon him for counsel have suffered a great loss.

THEREFORE BE IT RESOLVED, that a copy of these resolutions be sent to the relatives of W. A. Tolleson, M.D. and a copy be sent to the Journal of the Oklahoma State Medical Association.

COMMITTEE ON RESOLUTIONS
OKLAHOMA BAPTIST HOSPITAL

March 16, 1953.



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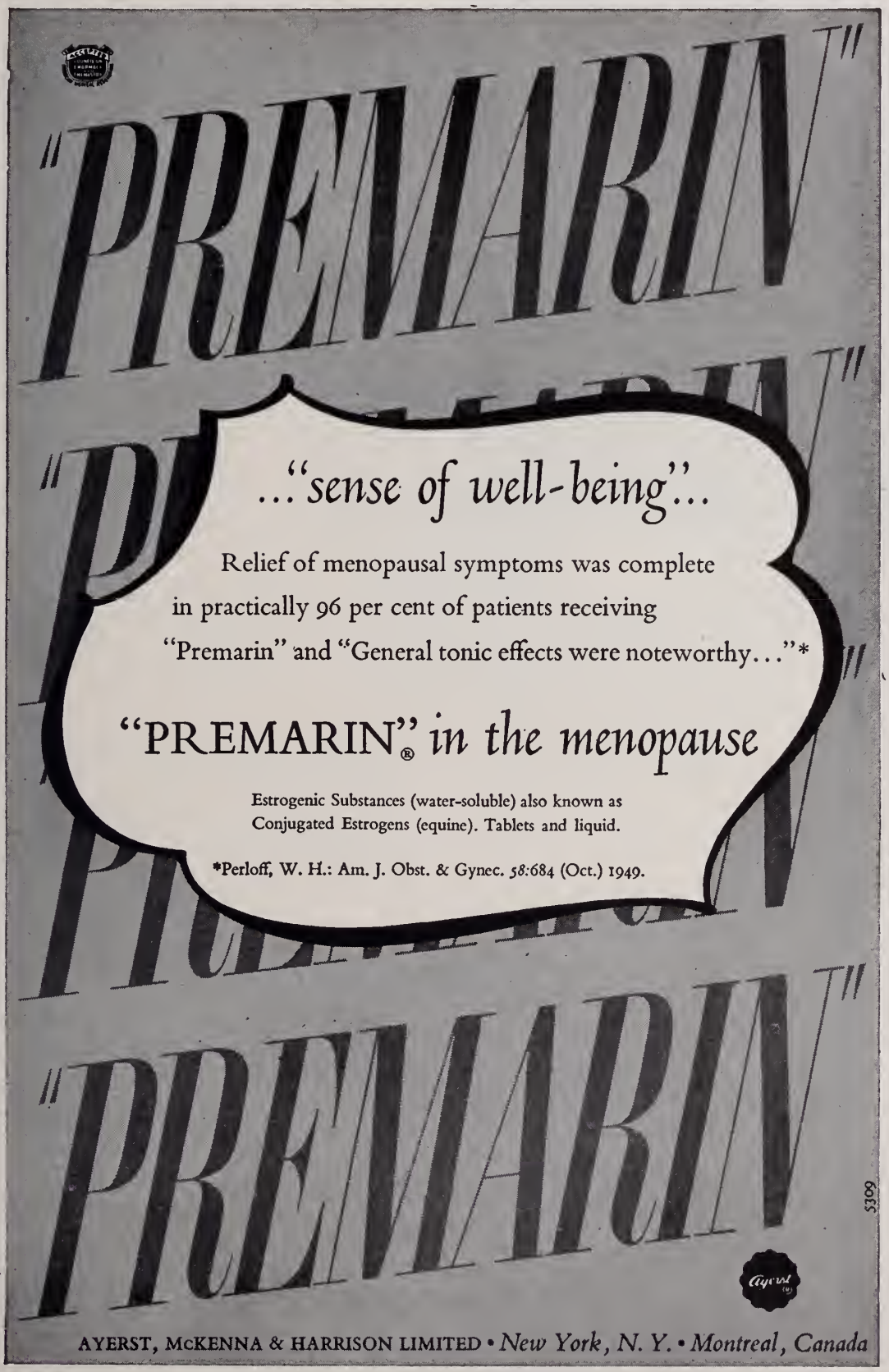
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*Perloff, W. H.: Am. J. Obst. & Gynec. 58:684 (Oct.) 1949.
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Doctor Howard

OKLAHOMA'S GUEST OF HONOR AT WORLD MEDICAL MEETING

Guests of honor from Oklahoma at the First Western Hemisphere Conference of the World Medical Association in Richmond, Virginia, April 23-25 were Dr. and Mrs. R. M. Howard of Oklahoma City.

Prior to the conference, the Governor of Virginia asked each state governor to appoint a physician from his state who would reach the age of 75 during 1953 to visit Virginia during the conference and tell of medical advances that have taken place during his lifetime.

Conference costs were covered by a grant from A. H. Robins Co., Inc.

Doctor Howard was born in 1878 and was graduated in 1901 from the University of Michigan Medical School. He is a diplomate of the American Board of Surgery and a fellow of the American College of Surgeons and of the International College of Surgeons.

APPOINTMENTS MADE

Grady F. Mathews, M.D., Commissioner of Health for the State of Oklahoma has announced the following appointments for superintendents of Health:

L. L. Spitzer, M.D., Ardmore, Carter County; Melvin C. Hicks, M.D., Pototoc-Murray; and acting superintendents, Seals L. Whitely, M.D., Durant, Bryan County; and Royce B. Means, M.D., Lawton, Comanche County.

HAVE YOU HEARD?

J. Hartwell Dunn, M.D., has been released from the United States Air Force and has re-opened his offices at 400 N.W. 13th St., Oklahoma City.

L. C. Kuyrkendall, M.D., McA'ester, has returned from a month's vacation in Florida.

John W. Williams, M.D., has opened his offices in Enid, Oklahoma, Broadway Tower Building.

Edwin Fair, M.D., Oklahoma City, spoke on "Accent on Youth" at the dinner meeting of the Methodist Men's group in Ponca City recently.

Frank A. Adelman, M.D., superintendent of the Western Oklahoma Hospital at Fort Supply, and *John L. Day, M.D.*, former superintendent of the hospital, held a special mental health study for faculty members of Woodward schools.

Royce B. Means, M.D., has established his office in Lawton.

C. M. Bloss, M.D., has recently moved from Holdenville to Houston, Texas.

A. N. Deaton, M.D., Wewoka, attended the New Orleans Graduate Medical Assembly in March.

Loyal Lee Conrad, M.D. of the Oklahoma Medical Research Foundation and the Oklahoma State Heart Association, was speaker at a meeting of the Clinton Rotary club.

William G. Husband, M.D. has been released from service and has returned to Elk City to practice.

Ralph McGill, M.D., Tulsa, has been appointed to the Board of Medical Examiners to replace the late Henry C. Weber, M.D., Bartlesville.

W. H. Smith, M.D., who has recently been re'eased from service, has -re-opened his office in Lindsay.

W. M. Featherston, M.D., Elk City, attended a postgraduate course at Charity Hospital, New Orleans, recently.

Mark Holcomb, M.D., Enid, represented the medical profession at the 1953 O.U. career conference.

MEDICAL SCHOOL SLATES POSTGRADUATE COURSES

The University of Oklahoma announces two postgraduate courses of interest to physicians throughout the state.

Emphasis will be placed on chronic diseases at the postgraduate course May 8 and 9. Guest instructors will be Harold Wolff, M.D., New York City, and John Sheldon, M.D., Ann Arbor, Michigan.

May 21 is the date of the practitioners conference on "Medical Emergencies." The conference will be held in the Medical School Auditorium at 7:30 p.m. All physicians are urged to attend.

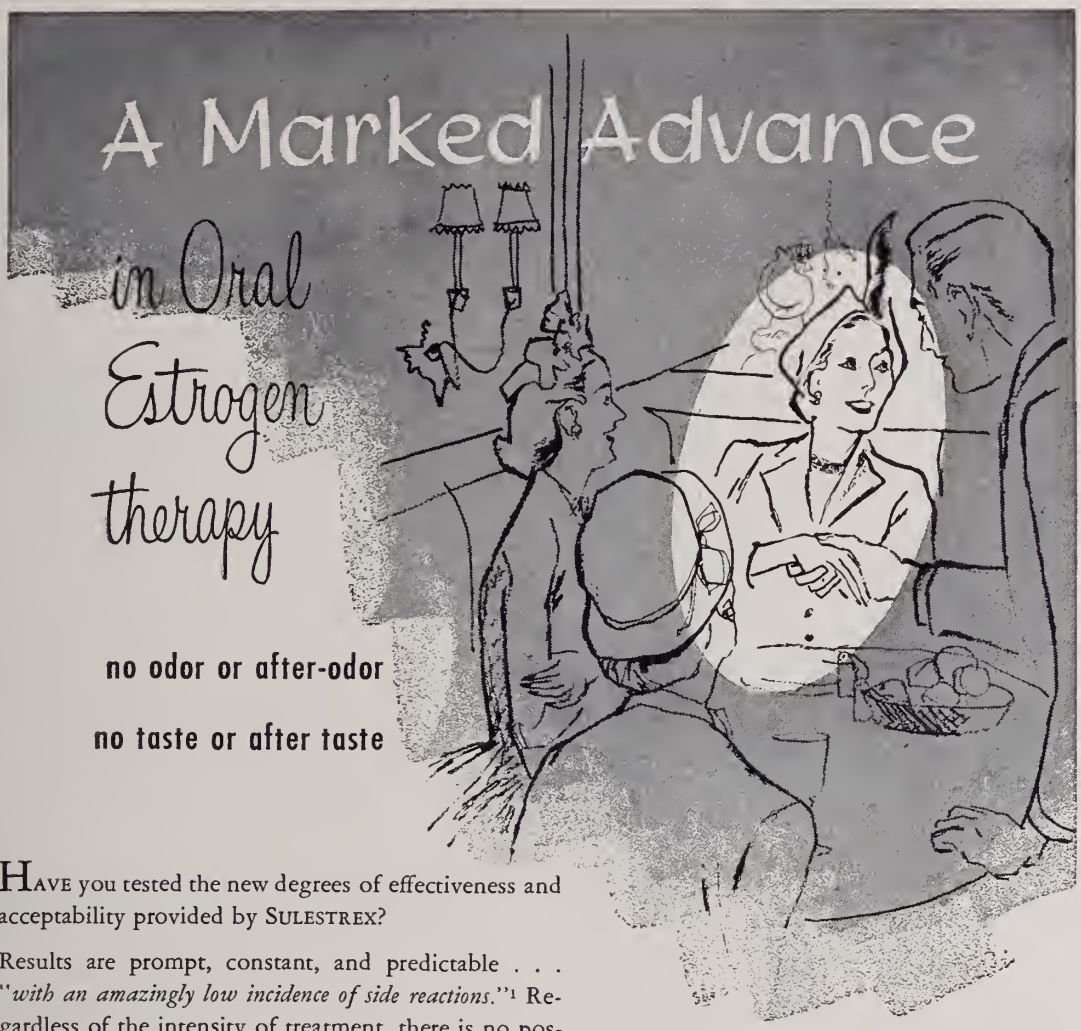
NEW ST. MARY'S HOSPITAL OPENS IN ENID

Open house and formal dedication ceremonies were held recently at the new $1,600,000 St. Mary's Hospital in Enid.

Operated by the Sisters of the Most Precious Blood, the hospital was built with $225,000 in donations and $590,000 in federal funds.

The five story structure is built in the shape of a "T" with the first floor housing business office, record library, doctors staff room, physical therapy department, pharmacy, chapel, gift shop, etc.

Laboratory and X-ray departments are located on the second floor as well as a number of patient rooms containing oxygen outlets, etc. On the third floor are surgery and medical surgical patient's room. The delivery rooms, labor rooms, entire O.B. department and two nurseries in addition to one suspect nursery and one premature nursery are located on the third floor. The hospital has four operating rooms and one cystoscopy room. The fifth floor has a large playroom for patients in the pediatric department, a sun deck, etc. The hospital also has a cafeteria and employee lounges.



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* AMA Council Accepted
** T.M. for Sublingual Tablets, Abbott
1. Reich, W. J. et al. (1952), A Recent Advance in Estrogenic Therapy. II. Amer. J. Obst. & Gynec., 64:174, July.

1-1648

CURRENT ACTIVITIES AT THE OKLAHOMA MEDICAL RESEARCH FOUNDATION

EDWARD C. REIFENSTEIN, JR., M.D.
DIRECTOR



This article, the seventeenth in the current series, will be devoted to a discussion of some unusual equipment which has been donated to the Oklahoma Medical Research Foundation to facilitate the program of clinical cancer research. In particular, we wish to acquaint our readers with the unique organization which has given this equipment to the Foundation.

The two pieces of equipment that have been donated for the study of cancer are specially designed and constructed instruments, called a "Mechanical Heart Pump" and a "Unit Hyperdemic Injector." These instruments represent an investment of more than $1,000.00 by the donor, the Mechanical Research Foundation, of East Elmhurst, New York.

The Mechanical Research Foundation was established four years ago by a group of engineers, who decided, because of their personal contact with patients who had suffered and died of cancer to devote their knowledge and skill toward the conquest of this dread disease. The Foundation is a non-profiit, charitable research organization, which is supported through the continuous generosity of those who believe that the effort and "know how" of the engineering profession can contribute not only primarily to the conquest of cancer, but also to beter management of other disorders of man. The founders of the Mechanical Research Foundation have gathered a nucleus of full-time engineers and experts, and have available for advice a large group of consultants in special fields. These engineering specialists devote their entire efforts to the design of specific pieces of equipment to facilitate investigation of medical problems, particularly those in the field of cancer research. Conferences are held to discuss the problems of research workers, complete specifications are outlined, and a plannned engineering effort is instituted. Close cooperation between the Foundation and the cancer research center is maintained to determine the effectiveness of th program.

The Mechanical Research Foundation is intrested in the performance of the instrumeuts they have donated to the cancer research effort, and has assembled a considerable body of data concerning the methods by which these special pieces of equipment can be adapted to various uses. This information has been obtained by pooling the results of experience obtained from research laboratories and universities using the instruments that have been designed. The members of the Mechanical Research Foundation have made special efforts to avoid unfavorable publicity and to make their services and instruments available only to investigators in the recognized research centers of the country. The success of the Mechanical Research Foundation rests on the basic philosophy that humanity can be served by the engineering profession if it comes to the assistance of medicine and places its techniques at the disposal of the men who are pushing forward the frontiers against disease.

Two pieces of equipmeut which have been donated to the Oklahoma Medical Research Foundation will be utilized particularly in the Clinical Cancer Section of the Foundation under the direction of Dr. Leonard P. Eliel. A brief description of these instruments follows:

The "Mechanical Heart Pump" is, in effect, a constant displacement pump and fulfills a definite need in medical research for the accurate delivery of specified quantities of fluid to a living creature (animal or mau) for extended periods. The principle of operatiou involves the moving of a body of fluid through a flexible tube by physically depressing consecutive sections of the tube in the direction of the flow. A pumping motion is delivered by a rotating eccentric depressor that acts against a spirally arrauged flexible tubing. Rotation of the depressor moves a trapped body of fluid along the tubing, and every timed revolution of the depressor shaft delivers an exact amount of fluid. This unique pump requires no check valves and has a minimum of moving parts. Its simplicity in design and construction miuimizes maintenance, assures freedom from contamination, and guarantees a high degree of precision accuracy iu its application. Thus, the instrument can be applied to such uses as a mechanical heart, intra-arterial transfusions, and similar procedures requiring a constant flow of fluid into or out of the body.

The other instrument is a precision "Uuit Hyperdermic Iujector" that injects a specified amount of fluid over a specified period of time. The priuciple of operation involves the action of the advance of a lead screw against the plunger of a hyperdermic syringe. The lead screw is advanced by a timing motor. A coupling device allows for a rapid interchange of timing motors for different injection rates. Suitable adaptors allow for the interchange of syringes of either 5, 10, or 20 c.c. capacity. The instrument has the unique feature of permitting the loading or discharge of air from the syringe without disassembly. The "Unit Hypodermic Injector" may be strapped to a patient, allowing him a reasonable degree of ambulation. The rates of injection can be varied so that it takes any selected period of time between 43 seconds and one week to complete a full hypodermic injection.

Not only has the Mechanical Research Foundation donated these instruments to the cancer program of the Oklahoma Medical Research Foundation, but the donor organization has expressed its willingness to adapt these instruments or others of similar or related design to the particular needs of any program that is developed in connectiou with the research program on malignant diseases.

The professional staff and the Directors of the Oklahoma Medical Research Foundation take this occasion to pay tribute and express their deep gratitude to the members of the engineering profession, and particularly to those of the Mechanical Research Foundation, for their generous assistance in the attack on cancer which is under way in Oklahoma.

IN SPRING ALLERGIES . . .

Allay Distress



Patients suffering from Spring allergies can be relieved promptly of annoying symptoms—with NEO-ANTERGAN.

NEO-ANTERGAN effectively blocks the tissue histamine receptors, affording quick comfort with a minimum of sedation or other undesirable effects.

Promoted exclusively to the profession, NEO-ANTERGAN is available only on your prescription.

Your local pharmacy stocks NEO-ANTERGAN Maleate in 25 and 50 mg. coated tablets in bottles of 100, 500, and 1,000.

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Research and Production for the Nation's Health

MERCK & CO., INC.

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RAHWAY, NEW JERSEY

BOOK REVIEWS

HEADACHES. Their Nature and Treatment. Stewart Wolf, M.D., Professor and Head of the Department of Medicine, University of Oklahoma School of Medicine, and Harold G. Wolff, M.D., Professor of Medicine (Neurology), Cornell University Medical College. Boston, Little, Brown and Company. 1953. Price $2.50.

What is more important in a physician's life than a broad, workable knowledge of headaches.

Here is a little book written in plain, readable, language with an appeal for both physicians and patients. It will supply the physician with many valuable leads and it will lead many patients to the physician.

Much of the comprehensive knowledge is supplied by our Stewart Wolf, Head of the Department of Medicine, University of Oklahoma. Every general practitioner should read this interesting, practical treatise and bring his own head up to date on headaches. Even though it may not add to his store of kuowledge, he should know what is in the book and how the facts are presented. This is important because the book is written for people who suffer from headaches and often it should be intelligently prescribed by the attending physician. In many cases it will do much more good than tablets and pills. While it should not take the place of the physician's psychotherapeutic responsibilities to his patient, it should serve as a splendid supplement. It should instruct and comfort his patient and conserve his time.

To be appreciated, the book must be read. The last two paragraphs will help the physician who reads this review, understand the importance of this work to physicians and patients.

It has been emphasized that there are a great many ways in which a person may acquire a headache, depending upon how the pain-sensitive structures in and about the head are stimulated. By far the greatest number of headaches are traceab'e to one or more of the three fundamental mechanisms outlined:

"(1) Vascular, involving pulling or displacements, or distension of blood vessels, usually arteries.

"(2) Muscle tightness, resulting from sustained tightness of muscles or without a local reduction in blood flow.

"(3) Mucous membrane, consisting of swelling and engorgement of structures in the nose and adjacent air spaces.

"Ninety per cent of headaches of the first two types and a substantial proportion of those of the third type occur largely as part of the human being's attempt to adjust to daily problems and challenges. The most frequently applicable treatment for headaches, therefore, is attention to the patient as an individual functioning in a social setting with his own special job to be done. It is important to take into eonsideration the values and asirations peculiar to him as well as the requirements of his job. Adequate attention to these aspects of human need, and at the same time requisite skill to traek down the occasional brain tumor, abscess, or ruptured aneurysm, is a requirement of comprehensive medieine."—Lewis J. Moorman, M.D.

STANDARD VALUES IN BLOOD. Errett C. Albritton, A.B., M.D. W. B. Saunders Company. 1952.

This compilation of data is exhaustive in its seope and abundantly annotated with bibliographical references. The format is extremely clear and the amount of material therein contained is almost staggering. It is the result of the efforts of a very large group of collaborators. It accomplishes the purpose of its editor, namely, "to gather and compile for publication the more basic established data on the composition and reactions of blood." Furthermore, one is impressed that the editor has also accomplished his purpose of "seeking the highest degree of authoritative references" for his work. The volume presents in tabular form essentially all of the physical properties of the blood, the plasma, and the serum. Various theories of blood coagulation are elearly illustrated. The distribution of blood types in various population groups is analyzed. The numbers and morphological characteristics of the formed elements of the blood, their staining reaction and enzymatie composition are effectively summarized. The influences of radiation on hematopoietic tissue and a tabulation of effeetive blood levels of various therapeutic agents both form unique contributions of this work. The work reflects in every page meticulous care in its composition and its editing. It should form a standard reference in all clinical and experimental laboratories which are involved in a study of the blood. It should be in every medical library.—R. M. Bird, M.D.

PRACTICAL DERMATOLOGY FOR MEDICAL STUDENTS AND GENERAL PRACTITIONERS. George M. Lewis, M.D., F.A.C.P. W. B. Saunders, Philadelphia 1952. 296 Pages.

The tuthor has, in this small volume, rather satisfactorily attained his objective of providing a concise and well illustrated text. It is unusual to find such adequate coverage of a field composed of many details in such precise fashion. The conjectural and controversial material of the subject has been eliminated.

The text is well illustrated with original photographs of high professional quality. These, as well as the author's style of writing and the logical organization of the material quickly provides a panoramic view of the field of dermatology, unfolded bit by bit for the reader.

The sometimes too brief eomments on treatment are supplemented by two ehapters on Therapy. One of these is essentially a review and statement of the general prineipals of Dermatolgic Therapy. The other is a eross indexed formultry with helpful comments on the use of the various types of Therapeutic measures and preparations.

A selected bibliography has been ineluded which is intended to serve as a guide to extend the reader's study of a given subject into more comprehensive writings. These include both general texts as well as specifie artieles.

This small volume is well recommended for the use of any student or physieian for a review of the subjeet, as well as for the praetieal points in diagnosis and treatment which it eontains.—R. C. Lowe, M.D.

THE JOURNAL

GUEST EDITORIAL

Westward, the Course of Empire

JOSEPH GARLAND, M.D.*
BOSTON, MASSACHUSETTS

The proposed publication of a history of medicine as it has developed in Oklahoma is another reminder of the debt that all modern learning owes to the successive phases of culture that preceded it and that are its legitimate inheritance. Bishop Berkeley's famous line "Westward the course of empire takes its way," written in the early eighteenth century "On the Prospect of Planting Arts and Learning in America," is itself a reminder that the extension of science and the arts over a large part of this continent is the result of an inevitable tide, the first waves of which made their impact on the Atlantic coast.

New England, like all other sections of the country, had its primitive aboriginal medicine that was not infrequently called on by the early settlers, who at times placed more faith in it than in any medical care that might otherwise have been available. The medicine of the white man in the early days of the colonies was in the hands of the governors, functioning as best they could by a sort of divine right, like ships' captains; and of a small group of preacher physicians who had picked up a smattering of medicine in the old country, that they might treat the bodies besides caring for the souls of their parishioners.

Massachusetts medicine may thus be said to have begun with Deacon Dr. Samuel Fuller, a *Mayflower* passenger, and Giles Heale, a barber surgeon who was a member of the crew of that amazing vessel which, like a trolley car, seems always to have had room for one more. Ten years later, in 1630, Governor Winthrop brought with him to the settling of Boston William Gager, "a right Godly man and skilful chyrugeon." Gager did not long survive and Fuller was borrowed by one after another of the adjacent settlements until he too died, in 1633, a victim of the smallpox.

The first accredited physician in Massachusetts was probably John Clark, who had received a medical degree in England and came to these shores about 1638. He was the founder of a line of six doctors of that name, the last of whom died in 1805. By mid-seventeenth century New Englanders were going to Europe for their medical training and before long certain names that have recurred through many generations began to appear.

Zabdiel Boylston introduced inoculation against smallpox into this country in 1721 and Benjamin Waterhouse, of Cambridge, first employed Jennerian vaccination in 1800. Joseph Warren, a prominent young surgeon, died fighting in the ranks at Bunker Hill. Edward Augustus Holyoke, of Salem, was born in 1728, the son of a president to be of Harvard College. He graduated in arts from that institution, but studied medicine by apprenticeship. The first president of the Massachusetts Medical Society when it was established in 1781, he lived to the great age of "one hundred years and eight months, lacking one day."

Those who are associated with the *New England Journal of Medicine* like to remember that it is the direct lineal descendant, without the loss of a systole, of the *New England Journal of Medicine and Surgery*, established in January, 1812. Six and a half years later, on July 4, the cornerstone of the Massachusetts General Hospital was laid. The original edifice, which still houses the medical wards, was built, according to the specifications of its trustees, "of stone and of that kind called granite." As a result of legislative generosity the stone was "hammered and fitted for use" by the convicts at the neighboring state prison in Charlestown.

Events that have had their place in shaping the course of medical progress are part of our total heritage, regardless of the locality in which they happened to originate — the classic observations of Jacob Bigelow, published in 1835, on "Self-Limited Diseases"; Crawford Long's first use of ether as an anesthetic in Georgia in 1842 and its public demonstration at the Massachusetts General Hospital in 1846; Reginald H. Fitz's paper on "Perforating Inflammation of the Vermiform Appendix," which appeared in the *Boston Medical and Surgical Journal*, successor to the *New England Journal of Medicine and Surgery*, in 1886, and so on down to more recent times.

By the simple fact that the English speaking conquest of this continent advanced from east to west, the first independent medicine of America developed on the Atlantic seaboard. But the value of tradition is in the inspiration and the example it affords, and this is property common to us all.

*Editor of the New England Journal of Medicine.

1. Viet's H.R. A brief history of medicine in Massachusets, 194 pages. Houghton Mifflin Company, Boston and New York, 1930.

THE PAST IS PROLOGUE

The informed members of the State Medical Association are aware of the concerted efforts of the Association and the State University to gather all available data on the history of medicine in Oklahoma. The present widespread interest in the history of medicine in the U. S. makes it incumbent upon us to see that Oklahoma does not constitute a gap in the medical history of our country. Though it is too late to write the early history of medicine in Oklahoma with satisfactory continuity, individually the members of the Association must do what they can to close the gaps by proffering full cooperation in connection with this important undertaking.

Allen K. Krause once said, "Some day a man will write a new kind of history. Its keynote will be the discipline of mankind by disease." This statement justly emphasizes the importance of medicine in the history of all civilized people.

The title of this editorial appears in front of the National Archives Building in Washington. For our present purposes it should read "Your Past is Prologue." The history of medicine in Oklahoma must be prefaced by your past. It may be more important than you think. The archivists say, "Never throw anything away." As an example of how things considered of little significance may in time take on historical importance, attention is called to a notation in *Armed Forces Medical Library News* April, 1953. It is reported that in an old book on the history of medicine the cataloger discovered ". . . a bill from Brentano's, date 27 May, 1893 to Doctor Billings for four books whose list price totals $4.00. Are these mysteries, juveniles, or a combination of both? Did Billings read them, or did he merely pass them on to other persons unknown? Is there a historian who would like to reconstruct Billings' life and character on the basis of this hitherto unknown document? More pressing, is it incumbent upon the Library to preserve this fragment of the 'total record'?".

John Shaw Billings was founder of the Surgeon General's Library (now Armed Forces Library) and spent 30 years building what is now recognized as the greatest medical library in the world. In the light of history, the bill from Brentano's (paid 1 June, 1893) has lost monetary significance and becomes an important part of the Billings record.

It is said that history is a record of events. Great or small, we have a part in current events; their significance may not appear until tried by fifty or a hundred years.

It has been said that history is clarified experience.

We partake of human experience. Its clarification and recording constitutes our debt to posterity. Cervantes said, "Your pen is your tongue." Now is the time to put your experience on the line.

Clio, the Muse of History, is waiting. Her "cylindrical box" holds no parchments on Indian lore, no manuscripts on the white man's occupation of this land of ours, no treatise on Indian medicine, no early day document on the white man's medicine on the plains.

Conscious of this vacuum, the Committee on Medical History in Oklahoma appeals to every member of the medical profession to scour the land and grub the grass roots for unrecorded facts. All personal knowledge of significance and all discovered data relating to early day medicine should be reported to the University of Oklahoma Department of Archives at Norman or to the Chairman of the History of Medicine Committee at the State Medical Association Office. Likewise, all tangible items of interest should be transmitted to the Department of Archives. Let the facts be known to the Archivist and the historian rather than trouble the archeologists with their puzzling fragments.

PHYSICIANS AND THEIR CIVIC RESPONSIBILITIES

While communities are dependent upon the medical profession for good medical care and the security of public health, physicians must never forget that they must look to the community for patronage and for all the amenities of life. The relationship is such that the physician cannot escape certain responsibilities in connection with civic interests. In the January 31 issue of the *JAMA*, these responsibilities are discussed on the President's Page by Dr. Louis H. Bauer. In this discussion the President of the A.M.A. rec-

ommends that physicians join their local chambers of commerce and become constructive participants in community affairs. In the course of the discussion he refers to a letter written by Stanley C. Draper of Oklahoma City who is President of the American Chamber of Commerce Executives and expresses the hope that all physicians read it. To all who have read the President's Page and the letter, this comes as a friendly reminder. To all who have not, this may be considered as a timely suggestion that they do so without delay.

There is no security in individual and home life without cooperation in community life.

MRS. WALTER FERGUSON
Another Deserving Doctor's Daughter

The May issue of the *Journal* carried a notice of the appointment of Mrs. E. Lee Ozbirn to the Board of the Women's Medical College of Pennsylvania. Later we learned that the versatile Mrs. Ferguson, so well known in the newspaper world, also had received the same signal honor. She is the daughter of Enos Osborne Loomis who located at Boggy Depot, Oklahoma, in 1887 where he practiced medicine until 1906, when ill health forced him to retire. Mrs. Ferguson finished her college career at the University of Oklahoma in 1908, and married Walter Ferguson, son of the sixth territorial governor of Oklahoma, T. B. Ferguson, in the fall of the same year. The Fergusons bought a weekly newspaper at Cherokee, Oklahoma, where they lived until 1920, when they moved to Oklahoma City, where Walter was connected with the First National Bank. In 1928, he was made Vice-President of the National Bank of Tulsa and they moved to that city.

Mrs. Ferguson started her career as columnist on the *Cherokee Republican*. After moving to Oklahoma City she did a daily column for the *Oklahoma News*. Soon the popular column was taken over by the Scripps - Howard Newspaper Alliance in Washington and syndicated to its chain. The columnist says, "Lucky me!" We say, capable, resourceful Mrs. Ferguson who has written with so much charm and common sense while keeping her home and rearing her children.

Who could be more deserving of the appointment to the Women's Medical College of Pennsylvania National Board of 100 women leaders in the affairs of the United States. Oklahoma is proud to be so well represented on this Board. But why shouldn't doctors daughters guide the destiny of this great women's college.

THE 60TH ANNUAL MEETING OF THE O. S. M. A.

Though operating in a world geared to material progress and monetary profits, the Oklahoma State Medical Association maintains its position on a high humanitarian plane, pursuing its humanistic course with unselfish devotion.

To sit in the Council and the House of Delegates and witness the patient deliberations in search of truth and equity in the solution of vexing problems posed by human aberrations was a chastening experience. Enough to make one proud of the profession and hopeful of the future.

The program was in line. The dispensation and acquisition of scientific knowledge for the benefit of humanity.

AMA PRESIDENT'S REPORT TO BE BROADCAST

"American Medicine's Report to the Nation," an inaugural address by Dr. Edward J. McCormick of Toledo, Ohio, incoming President of the American Medical Association, will be broadcast at 9:00 p.m. Wednesday, June 3 by the following Oklahoma radio stations:

Ardmore	KVSO
Enid	KCRC
Lawton	KSWO
Muskogee	KBIX
Oklahoma City	KTOK
Tulsa	KRMG
Wewoka	KWSH

Scientific Articles

THE MANAGEMENT OF NEUROGENIC BLADDERS FROM THE REHABILITATION STANDPOINT*

JOHN W. DEYTON, M.D.
OKMULGEE, OKLAHOMA

The results in rehabilitation are dependent upon many factors including previous definitive medical care, solution of orthopedic problems, stability of genito-urinary tract, psychological reaction of the patient to injury and disability, vocational outlook and what the future holds for the handicapped man or woman. In the rehabilitation of the paraplegic type of patient there is no specialty more important to the psychiatrist than urology. All of our work and much of our results depend upon the team approach. In those with spinal cord injury the urologist really carries an extremely large part of the burden because bladder physiology and function have been markedly altered and possibly sexual competency lost. Let us look at a typical paraplegic patient and see why this is:

Henry Jones is in the prime of life with a good job, a family to support and an important member of his community.

He is involved in an accident in which he suffers severe injury to the cord. He is immediately paralyzed from his waist down, unable to work, to support his family and carry on community functions. Not only is he unable to move his lower extremities but he finds they have been deprived of sensation and are to him useless, numb, and dead. On top of that, Henry finds he has lost control of his bladder. He can neither empty it, nor prevent it from emptying, nor even know when he voids without feeling with his hands to see if he is wet. Perhaps he is under tidal or manual drainage or catheterized two or three times a day. If this is not the case he finds when he moves his bladder leaks, when he wakes his bed is wet. This is a tremendous shock to him. If it cannot be corrected, he will be socially unacceptable and therefore home bound. If not at first, he will sooner or later realize his sexual functions have also been markedly affected and altered if not lost. He may find he is unable to engage in marital relations. Thus, he is not only paralyzed from the waist down but sick at heart and disturbed in mind. He is really a sick man as a total entity and it will require all the professional acumen of every member of the medical team, of every specialty, to salvage him. Upon you as urologists fall an extremely heavy responsibility for Henry's future.

In health there is no more beautifully integrated and coordinated function of the human body than micturition. Higher centers of the central nervous system both voluntary and involuntary correlate all the contractile phenomena of the bladder and urethra into a remarkably efficient mechanism which is almost flawless. When the cord is injured sufficiently to produce paraplegia, this perfectly balanced well integrated function is disturbed.

The sequence of events following spinal injury is as follows:

1. Spinal shock.
2. Loss of vasoconstriction.
3. Urinary incontinence.
4. Recovery from shock: The bladder be-

*Presented before the Oklahoma Urological Association February 28, 1953.

comes distended by return of vascular and visceral tone, resulting in overflow incontinence.

5. Resolution and recovery with the necessary adjustment and stabilization to altered function.

It is not necessary for present purposes to discuss the immediate post traumatic urological problems of this class of patients. So let us skip all that period and pick up the cord injured patient on admission to the Rehabilitation Center months or years after the injury.

We can rougly classify spinal cord injuries into four main groups by the spinal level of the lesion:

I. Brain stem to D-6.

II. D-6 to D-11.

III. D-II to L-5.

IV. Below L-5.

Injuries in groups I and II, that is above D-11, result in automatic bladder function and usually lend themselves quite favorable to training for automatic bladder control. This is true even if the lesion is a complete trans-section. The reason is that sympathetic and parasympathetic pathways have not been disturbed. Groups III cases, D-11 to L-5 are more difficult and result in an autonomous bladder. The injury here is to the lower motor neuron in contra-distinction to upper motor neuron above the D-11 site. Group IV cases, below L-5, are the worst because, if the injury is complete all innervation to the bladder and sphincters is lost. Some consider them as hopeless so far as developing control is concerned and remaining dry and safe.

All neurogenic bladders resulting from spinal cord injuries must be treated by a well organized plan. They will always require close observation. Complications continually arise and may cause a well controlled bladder to regress markedly. Every paraplegic patient will need close urological supervision as long as he lives.

Our plan for training patients with cord injuries for automatic bladder control is as follows.

1. Relatively high daily liquid intake, 3000-3300 cc. This is accomplished as follows: Two 8 oz. glasses liquid on arising, at breakfast, mid-forenoon, at lunch, mid-afternoon, at supper (5:00 P.M.), at 7:00 P.M. and one glass at 9:00 P.M. All liquids are counted. Carbonated and alcoholic drinks are advised against.

2. An alarm clock schedule for attempting voiding is set up. To begin with 20 minutes after each fluid in-take but if the patient has wet in the meantime the time is shortened until found dry.

3. Patient, nurse and attendant analysis of each case to try to find a method of inducing bladder emptying, trigger zone stimulation, push-ups, pressure etc. and capitalize on this.

4. Self analysis by patient to find and recognize the call to void or warning signal. This signal is always to be honored.

Each case will be a law unto itself and there will be great variations.

Experience has revealed the neurogenic bladder problem to have seven facets from the standpoint of retraining for automatic bladder control:

1. Initiate emptying.

2. Secure adequate emptying.

3. Find and honor the warning signal for voiding and avoid being wet.

4. Effect of liquid and food intake on bladder elimination.

5. Effect of physical activities on bladder emptying.

4. Role of emotional factors.

7. Personality complex, drive, motivation, and cooperation.

To initiate emptying: The place of choice of course is the commode. The position of choice is sitting. Voiding can often be induced by stimulation of certain trigger zones about the pelvis, perineum, lower abdomen and groins. Sometimes stroking the pelvic hair, inner surface of the thigh, the genitals or the lower abdomen. Gentle tapping is tried if stroking fails. Stimulation of the umbilicus by turning in it the eraser end of a lead pencil is occasionally successful. This is because of the rudimentary structures in the urachus connecting the bladder and the umbilicus. When once a

trigger mechanism is found which may be used to induce voiding it is capitalized on and trained. It is really spinal reflex at work and it lends itself to strengthening and re-enforcement through training. If none is found then push-ups from the commode seat are tried. This is an elbow extention (triceps) shoulder depression (latissimus dorsi) forceful contraction increasing intra-abdominal pressure resulting in voiding. It is a reliable method and always completely safe. Finally manual pressure on lower abdomen. Both thumbs are thrust straight back sideways just below the umbilicus, then the pressure directed downward to which is added finger pressure across the lower abdomen in and down. Not too safe a method but effective. This is the final procedure and will usually take care of the second facet of the problem, namely adequate emptying.

The third is a sensory problem of finding a substitute mechanism for the normal urge to void. It is called the warning signal or call. Most of our cases above D-11 have re-established their call rather well and in a high percentage it will simulate the normal desire to empty the bladder. Those below D-11 have more difficulty and the lower the lesion the greater the difficulty. We have had no patients with lesions below L-5 but while at New York University I learned these are the most difficult. There are remote warning signals that can sometimes be found and used regardless of the level of the lesion. Among these are such as a feeling of fullness in upper abdomen, mouth filling with saliva, a wave of nausea, a chilly sensation go over body, sensation of goose flesh, hair standing on end, sweating of palms etc. These are sympathetic and parasympathetic phenomena and when present are reliable, good to work on and train with and can be strengthened.

The fourth facet, the effect of fluid and food intake on the paraplegic bladder is quite variable. Most patients will void within a half hour from the time of intake, some in five minutes. Each patient is to find that critical time and beat it.

The problem of holding or inhibiting bladder emptying is greater for patients with low lesions and usually pretty good for those with lesions above D-11. It takes a long time to re-develop the ability to restrain the act of micturition but it is attainable in the intelligent cooperating patient. Occasionally a patient will go three or four months and not have more time than enough to pick up a urinal at his side and put it in place before the bladder empties. Then almost suddenly he finds he can hold until he gets to the commode. What actually happens in my opinion is that he learns to recognize an earlier warning signal which gives more time to get there.

Severe physical activities may cause the bladders under best of control to leak in direct proportion to the severity and extent of the activity. The mechanism at work is actually increased intra-abdominal pressure hammering down on a partially filled bladder. When going out, and traveling all paraplegics should be protected against urinary accidents and embarrassment. Men should wear male urinals and women should wear padded water proof pants.

Emotional factors, grief, fright, tension, domestic difficulties, etc. can play havoc with the best controlled nerogenic bladders. We had a D-6 lesion recently discharged with adequate control, excellent warning and enough holding power that she always got to the bathroom on time. She was never wet by day but did have nocturnal eneuresis. She attained maximum benefits of treatment, received vocational training and went out to her first job to face the world. She was for the first time living alone on her own. The responsibilities were great. Within a month her bladder went haywire. She had such stress incontinence she had to go under the care of a local urologist.

In all this program, intelligence, understanding, cooperation, motivation and drive on the part of the patient is paramount. He is the prime player on the rehabilitation team, and must carry the ball and understand why. The professional members of the team can only call the signals. The player, the patient, must execute the play.

Mention was made above of nocturnal eneuresis. This is a greater problem than remaining dry during the day. One would think physical activity would cause more leaking than lying in bed sleeping but the contrary has been true in our experience. Moderate physical activity I'm sure assists in stabilization of the neurogenic bladder, despite the fact that violent effort resulting in marked increase in intra-abdominal pressure may result in accidents and embarrassment. In the matter of water discipline not more than three paraplegics out of 10 can

take liquids as late as 9 P.M. according to the schedule and remain dry during the night. Four out of 10 will still be wet with last liquids taken at 7:00 P. M. For these the last is given at 5:00 P.M. and still some are wet. The next approach is to have patient, nurses, and attendants check the bed every hour for a few nights to determine when voiding occurs. Then drop back one half hour earlier than that time and wake the patient to void. About one in 10, usually low lesions, will void so irregularly no pattern can be established and a wet bed must be accepted as a part of the disability.

It should be mentioned, of course, that acute illness and infection complicates the whole problem and causes a good bladder regime to be broken. All these cord injured patients are particularly susceptible to G. U. infection.

Some mention should be made of the urological criteria for admission of the paraplegic type of patient to a Rehabilitation Center. The G. U. tract should be stabile and relatively free from infection with no history of bouts of chills and fever. If calculi are found they should be removed prior to institution of rehabilitation measures. It is advisable to have a cystometrogram but this is more important in the early stages of paraplegia than in old cases. By observation one can determine the gross cystometrics. It would be well to have urine cultures, IV pyelogram, blood chemistry including serum protein, NPN, calcium and phosphorus levels. Being in the early stages of organization and located at some distance from a Medical Center, we have found it necessary to carry on without these advantages, and it is felt they are not so important in the old as in the new case.

We will accept as a satisfactory result a neurogenic bladder that has the following characteristics:

1. Capacity 200-300 cc.
2. Residual of 60 cc or less.
3. Capable of controlled emptying within reasonable limits.
4. No incontinence.
5. We want them to be dry both by day and night but may have to accept in some a wet bed.

We do not always attain these objectives and may have to accept a result wherein the patient has improved, gained some control, is dry more of the time and has fewer accidents.

A few examples will illustrate the G. U. problems of a Psychiatrist in a Rehabilitation Center.

1. B.B. is a 25-year-old white female with a broken back at D-12 on November 21, 1951. Admitted to the Center September 9, 1952 on a b. i. d. catheter status. Catheterization was immediately stopped to the great horror and dismay of the patient and family. She had not sat on a commode in 10 months. It took every trick in the books to induce voiding, which did occur 10 hours later. The stimulus was push ups from the commode seat. She has been voiding regularly since on a strict schedule of water discipline and alarm clock regularity at the stool. She will allow nothing to disturb her voiding schedule. Once I met her in the hall in the early afternoon and said, "B. I'd like to see you in my office at 2:30" to which she replied, "Sorry, Doctor, can't see you then. That's my time in the bathroom." She went to void at 2:30 instead of seeing me.

2. M. T. is a 44-year-old white female D-5 paraplegic of 10 years duration. Etiology epidural hematoma. She was admitted to the Center in September wearing an indwelling Foley. On the third day I was to remove it and place her on automatic bladder management. The night before, the catheter came out. Much to her surprise she found she had some bladder awareness and voided a rather good amount five-six times a day. Within a week she had learned to get to the commode on time and was dry most of the time. She has improved to where she is dry both day and night but has to get up a little early to save being wet at usually arising time. M. presents one other lesson in rehabilitation urology to all of us: She was refused admission on paper basis, sight unseen, because there was no record of a urological survey in many, many months. The requested referral to a urologist was carried out and a bladder full of "rocks" was found: Seven stones she reports, varying from ¾" to 1½" in size.

3. D. B. is a white male D-12 paraplegic 25 years of age, injured 30 November 1951 who was first refused admission because of a golf ball sized trochanteric decubitus and a suprapubic tube. His orthopedist remon-

strated bitterly that we were letting him down after so much trouble in persuading him to come to the Center. He was eventually admitted in January '53 with his suprapubic tube. Questioning revealed that some urine was passing thru the normal channel. We just stopped draining the suprapubic tube and he was voiding one-two oz. about every hour. Then the suprapubic was drained only after voiding and the quantity delivered was less than an ounce. When the bladder was distended with a syringe, he was found to have a capacity of 200 cc and an acute desire to void. Obviously it was time for that tube to come out. His referring orthopedist was contacted by phone and asked to get clearance from the urologist for removal of the suprapubic tube which was done. His opening has closed completely and is tight. He has accidents yet because his holding power is not good, but he is definitely improving and can look forward to a bladder under control with dry pants and a dry bed.

But all our cases are not successes. We have our problems and failures.

To Wit:

4. J. W. is a 25-year-old L-2 spina bifida. He has been most resistant to bladder management though he is an intelligent cooperative young man. One factor unquestionably is that as a congenital case he has never known what bladder control is. He has not experienced the urge to void nor known the sensation of inhibiting. As far as we got with J. W. was that he learned to recognize the signal or call to void but it occurs so quickly he is wet. Urological consultation, which unfortunately had not been insisted on as an admission prerequisite, revealed a residual urine of three-four oz., hydroureter and hydronephrosis on one side and a tight sphincter. In this status he can never develop control. The solution to his problem rests on urological procedures. We believe the best approach might be resection of the bladder neck to relieve the degree of obstruction present and reduce residual to 60 cc or less. This would be excellent treatment for his hydronephrosis and hydroureter. It is the approach of the New York University group which Doctor Stapita leads and to whom I am so indebted for much of the background work of this paper. It is extremely difficult for any urologist to anticipate exactly how much tissue to remove to accomplish the desired result. If too much is taken the patient will be left with a constantly dribbling bladder. If too little is removed, he will still have too much residual. So it may be necesary to do two or three partial neck resections. When the proper urological status with reference to residual is attained, namely about 60 cc, the patient can be returned to the Rehabilitation Center for another attempt at automatic bladder training.

There is no point in attempting to develop an automatic bladder in the new paraplegic. The neurogenic bladder must go through several stages of evolution before reaching the reflex phase. They are roughly post traumatic atony, independent or autonomous function not lending itself well to training procedures, then hypertonic bladder and lastly reflex. The time element is widely variable depending on level of the lesion, extent and severity of the injury, spinal shock experienced and early treatment procedures.

How many paraplegics there are in the United States no one knows. The U. S. Public Health Service has estimated 85,000. This would mean approximately 1200 for Oklahoma in proportion of population. World War I resulted in only 400 paraplegics because nearly all of them died of kidney infection within a year. But World War II gave us 2500 paraplegics who are left with us because they were saved. In the same period there was not less than 15,000 civilian paraplegics and most of them are living. You are better urologists than your fathers were. You have more improved technique plus sulfonomides and antibiotics. You are not letting the cord injured patient die from ascending urinary infection. Some of the rest of us must figure out ways and means to capitalize on your gains and make this group of patients dry and safe and socially acceptable. That is the self assigned task of the Psychiatrist at the Rehabilitation Center. Our results at Okmulgee have shown that slightly more than 50 per cent of neurogenic bladders can achieve satisfactory automatic control, 20-25 per cent will be less satisfactory but yet acceptable, 15 per cent improved but results poor and less than 10 per cent outright failures.

CONTRAINDICATIONS TO THE USE OF BANTHINE IN DUODENAL ULCER

J. R. COLVERT, M.D.

OKLAHOMA CITY, OKLAHOMA

Banthine, since its wide publicity by Grimson[1,2] has been accepted enthusiastically by others, Brown and Collins[3]. Not until recently has it been suggested that it is not the panacea for ulcer.

I wish to report 22 cases of duodenal ulcer which did not respond so well to Banthine therapy. Namely, two cases of perforation, five cases of hemorrhage, 17 cases of obstruction which occurred while patients had been on Banthine one to six months continuously before complication arose.

Method

All cases of duodenal ulcer reported in this series were patients seen in consultation or referred to me for treatment because of the complications arising while on Banthine at dosages of 50 to 100 mg., four times a day, for duodenal ulcer. None of these cases were on good dietary management.

Results

Table I lists the patients in this series as to age groups and it is seen that ages vary from 22 years to 68 years and are a very representative group from the standpoint of age. It is of interest to note that all patients in this series are men; however, the incidence of complications, such as hemorrhage, perforation, and obstruction is much less in women.[4] The patients in this series had all been on Banthine continuously for from four weeks to six months prior to the onset of complication. Most patients seemed well pleased with the initial relief of symptoms produced by Banthine and four of the five hemorrhage cases stated emphatically they hemorrhaged without any symptoms prior to the hemorrhage. The other hemorrhage case was complicated by obstruction and had vomited for one week before hemorrhage occurred. In the two perforation cases one was having no distress while the other went back on Sippy regime for a few days before he perforated.

Table II shows that no patient was on Banthine less than four weeks. One patient was on Banthine for 40 weeks before seeing me. His first course of Banthine was four weeks at the end of which time he perforated. After leaving the hospital he again started his Banthine and continued taking it for about nine months until he obstructed and was required to have gastric resection.

In Table III, there are two cases of perforation, five of hemorrhage, and 17 of obstruction. This is a total of 24 complications in 22 patients as one of the perforated cases later obstructed and one of the obstructed cases hemorrhaged.

Table IV lists the treatment of these cases. Both perforations were immediately closed surgically and one later had a gastric resection for obstruction. Of the five hemorrhage cases, one was resected as this was his fifth hemorrhage, and four were placed on Sippy management. In the 17 cases of obstruction, 11 were easily controlled on medical management after the discontinuance of Banthine which has been shown to decrease motility and thus delay emptying through a narrowed duodenum. Five cases of obstruction required gastric resection after adequate medical trial except in one case where severe hemorrhage necessitated immediate resection. In one case of obstruction gastroenterostomy and vagotomy was done because of patient's age and the coexisting complication of a coronary occlusion 10 months previously.

TABLE I

Incidence of Age Groups

AGE	NUMBER OF PATIENTS
20-30	3
30-40	3
40-50	8
50-60	3
60-70	5

TABLE II

Number of Weeks on Banthine

WEEKS	NUMBER OF PATIENTS
4- 8	7
8-12	2
12-16	3
16-20	5
20-24	4
40 weeks	1

TABLE III

Complications

Perforations	2
Hemorrhage	5
Obstructions	17
Total	24*

*The reason this total is more than 22 is that one obstructed case hemorrhaged and then in another case the patient perforated and 9 months later developed an obstruction after being on Banthine for 40 weeks.

TABLE IV

Treatment

Complicotions	Medicol	Closure	Resection	Gostroenterostomy & Vagotomy
Perforation	0	2	0	0
Hemorrhage	4	0	1	0
Obstruction	11	0	5	1

Summary

Here again, the total is 24 complications in 22 patients and is explained by the footnote in Table III.

In this paper 22 cases are reported in which Banthine was of no value in preventing complications of peptic ulcer. Ruffin[5] states "there is no conclusive evidence that the ulcer heals more rapidly under Banthine than under conventional therapy." Banthine is very effective in relieving the pain of ulcer without producing any degree of healing and this gives the patient a false sense of security and probably increases the incidence of complications due to dietary neglect of the ulcer, as all cases in this series were on poor ulcer management at the time complication developed.

Levin, et al[6] demonstrated that Banthine intramuscularly reduces volume of gastric secretion and concentration and output of free hydrochloric acid but 100 mg. doses of Banthine orally have no effect on the concentration of free hydrochloric acid, and taken over a period of one to six months does not alter the basic gastric secretory level.

Winkelstein[7] reports that in seven patients with active ulcer while on Banthine he was unable to produce pain with the Palmer Test. This was interpreted that the effect of the drug in relieving pain is not due to control of gastric acidity. This is one of the effects of Banthine which make it a dangerous drug in the treatment of ulcer. It abolishes the antral spasm and pylorospasm which are probably the cause of ulcer pain without adequately controlling acidity. Thus, a patient's ulcer may get progressively worse without the patient's or doctor's realization.

It is of interest to note that 11 cases of obstruction in his review were relieved by proper medical management after the discontinuance of Banthine.

Conclusion

(1) Banthine certainly has not replaced conventional ulcer therapy and in the uncooperative patient probably should not be used as it is far superior as a pain reliever than as a suppressor of gastric acidity.

(2) In cases of marked narrowing of the duodenal cap or in cases of gastric retention from edema of cap or spasm of pylorus, Banthine is contraindicated.

(3) If Banthine is used it should be employed in conjunction with adequate ulcer management—dietary as well as psychotherapeutic.

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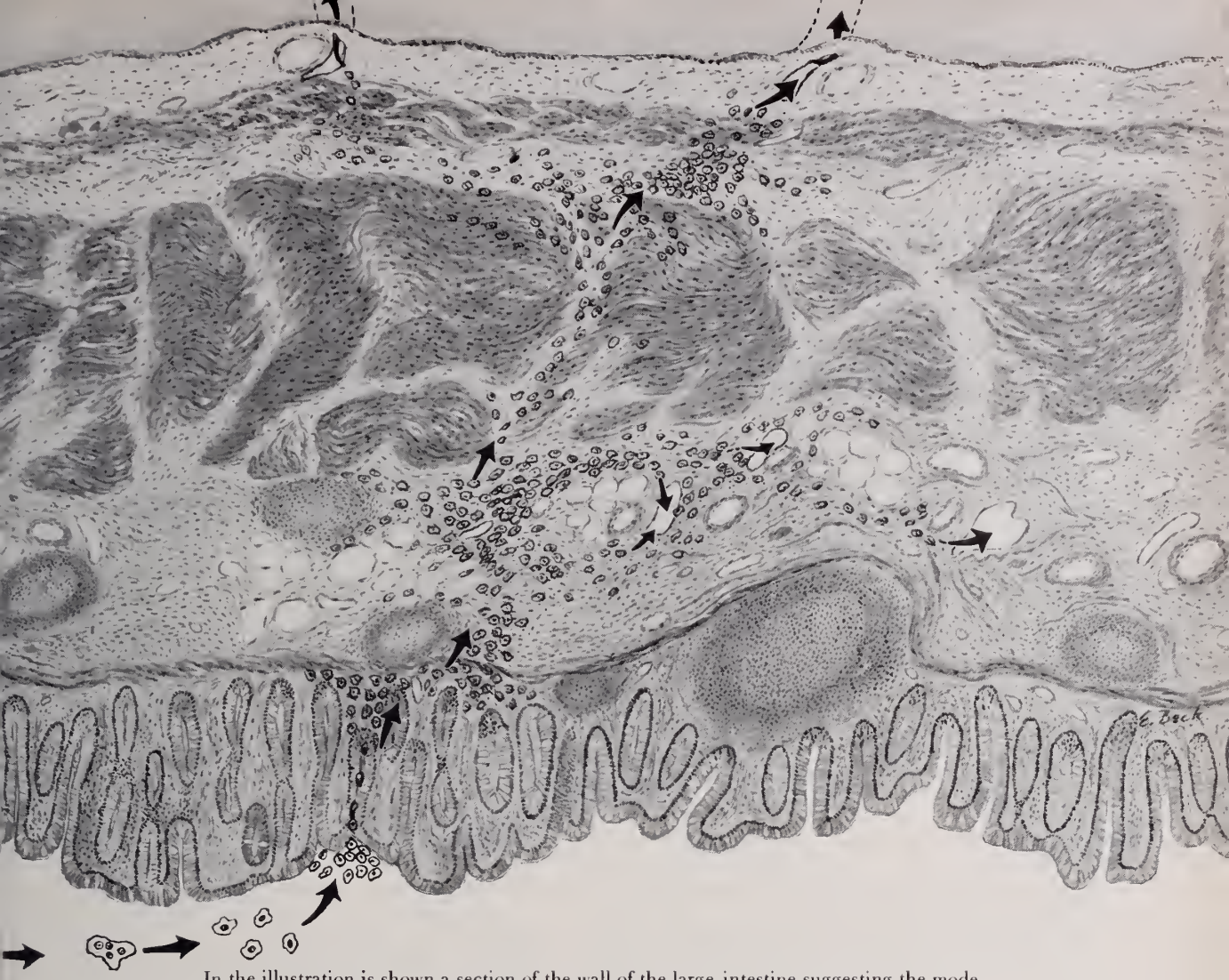
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In the illustration is shown a section of the wall of the large intestine suggesting the mode of invasion of *Endamoeba histolytica* into the various levels; the mesenteric venules lead to the liver and escape of some of the parasites may cause an amebic abscess of the liver.

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*Weingarten, M.: Proctology Symposium: Amebiasis: Medical Aspects, Mod. Med. *20*:121 (May 15) 1952.

Special Articles

HISTORY OF MEDICINE IN OKLAHOMA

The following represents in abstract the brief addresses presented by Gaston Litton, Jim Babcock, Savoie Lottinville and Doctor Wardell at the meeting of the History of Medicine Committee March 19, 1953, convening in cooperation with the University and its departments, History, Archives and the Press.

Every member of the Association should read these articles and become medical history conscious.

GENERAL STATEMENT

GASTON LITTON*

The wonderfully heroic story of medicine in the twin territories and in the state of Oklahoma has not been told. It is a story that needs telling. It is a story that cannot now be told, except perhaps from the point of view of an individual doctor who is reminiscent and who has been observant of many phases of medicine of which he was not necessarily a part. The fundamental reason why the story of medicine in Oklahoma has not yet been told, and cannot yet be told, is simple and it is relatively easy of solution. The materials, original records and master files of basic literature, have not been collected, the wheat sifted from the chaff, the worthwhile properly identified and set up for use. When these varied materials have been assembled, and when they have been prepared so that they may be used with a minimum of time lost, then the writer who combines a training in historical research with a profound knowledge and appreciation of medicine can tell the story.

*Archivist of the University of Oklahoma.

IMPORTANCE OF ARCHIVES

JAMES M. BABCOCK*
NORMAN, OKLAHOMA

The significance of medicine in the present day society of Oklahoma is great. The understanding of this significance is perhaps narrow. So that this understanding may be broadened, let us take steps now to preserve the heritage of medicine in Oklahoma.

A firm foundation for a broader understanding of the place of medicine in Oklahoma's history, and in particular the place of the individual physician, may be established by the preservation now of the extant archives of medicine in our state. By means of these records the student of so-

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ciety can properly assess the growth and development of the practice of medicine in a society made unique because of the element of Indian civilization which survives from a not too distant past.

An archives of medicine in Oklahoma will include the records, files, papers and reports of a physician's practice, professional associations and writings. Such varied forms as correspondence, diaries, journals, ledgers, scrapbooks, minute books, membership lists, and photographs may be preserved in the original or in transcript, photocopies, or sound recordings. All of which gives insight into the complexities of this phase of our social organization.

Perhaps our lack of understanding of the significance of such materials has relegated them to the insignificant repository such as an attic, basement, closet, storage room or garage in the many counties of the state. The University of Oklahoma, in cooperation with the Oklahoma State Medical Association, is now prepared to receive into its collections these historically important records. Once the job of collection has been completed, a competent researcher can begin the writing of the story of Oklahoma medicine.

DEALING WITH MEDICINE HISTORICALLY

SAVOIE LOTTINVILLE*

"Progress" has become a very common word in our language. Almost everybody uses it, but few people except historians think of it in historical or critical terms. Somehow, it has come to mean what is transpiring under our noses. This is unfortunate because it robs the word of its all-important signification, which is perspective.

As late as 1918, Dean LeRoy Long of the University of Oklahoma Medical School delivered a paper on pre- and post-operative catharsis before a meeting of the Tri-State Medical Association. The great Dr. Jabez Jackson criticized the paper from the floor in rather vigorous terms, suggesting that such catharsis, then commonly indicated in abdominal operations, could be justified on abundant grounds. The happy sequel was that Doctor Jackson went to see Dean Long a year or two later, after much study, to apologize for his critical statements. The researches of Dean Long, he said, pointed away from such catharsis. In the years since, medical and surgical practice seems to have abandoned the old road entirely.

I recite this incident from Dr. Basil Hayes' account of Dean Long only because it has some bearing upon the meaning of the word "progress," and upon historical perspective. "Progress" is where we are now, in relation to where we once were. It is deeply imbedded in two parallel courses of development: the technical or scientific, on the one hand, and the cultural or social, on the other. We must have both if our society is to achieve its best ends, but we must not assume that, because these two channels lie close together, they always complement each other. On the contrary, they often do not. Although this statement may seem improbable to you, let us recall that social development sometimes lags so far behind the technical or scientific that they may even become irreconcilable. Thus, while the control of enteric diseases hangs very largely upon the proper disposal of wastes, there are still cities in the land which, in the

*Director of the University of Oklahoma Press.

absence of a strongly developed social responsibility, allow these wastes to pour into streams, thereby threatening the results of the most highly developed measures in medicine and epidemiology.

On the other hand, the increasing complexity of medical and surgical sciences, coupled with a remarkable degree of specialization, has often left society with an inadequate notion of the nature and extent of its gains from these great professions. And since every practitioner cannot be an individual historian for his patients, the store of medicine's contributions is imperfectly understood.

I think you must now guess what I am getting at. On the one hand, society must discharge more completely than it has done in the past its responsibility to itself. It must heed and perform the duties that medical science has called upon it to perform. On the other hand, the medical profession must forever be about the business of informing the public of the parallel and complementary character of medicine and cultural developments. In part, this means the now established technique of public relations. In part, it means the investigation and recording of the vastly important medical contributions to society.

I can make no more important suggestion than to indicate that our people in America are anti-authoritarian. They are impatient of any system or tendency which requires them to accept any fact, doctrine, or plan on faith. They are deeply attached to individual thought and enterprise.

The professions, if we are entirely honest with ourselves, have not always had a sufficient regard for these facts. I include in this statement law, engineering, and theology as well as medicine. The obligation of any enterprise in a society such as ours is to adjust itself to this salient feature of our social psychology. It can accomplish the purpose best, it seems to me, by frequent and open communication with the public.

In this connection it is well to remember that the structure of American society has changed vastly in the last 35 or 40 years. College-educated people form a considerable part of any audience that industry or the professions are likely to address. These people have two highly significant characteristics: (first) they are opinion makers for other segments of society, and (second) they have a more highly developed critical sense than is ordinarily assumed. A successful approach to the public depends in considerable part, therefore, upon the manner in which this particular segment is addressed.

Medicine, of all the professions, prompts a curiosity on the part of laymen which borders on the insatiable. It accordingly possesses an advantage which no other profession can attain. People are eager for information on the origins, development, and achievements of medical science. They will go to great lengths to get it—which is perfectly natural, since medicine is occupied, at least in the public mind, with the great ponderables of birth, life, and death.

One of the most satisfactory means of satisfying this curiosity is to deal with medicine historically, and even better, locally. I am only a layman, but I am nevertheless aware that medicine has had a rich and interesting development in Indian Territory and Oklahoma. No one who has read Doctor Moorman's autobiography can have missed that fact. It is a history enormously worth exploiting, and I urge the historians and the medical profession to do so at the earliest possible moment. I say this with the same conviction that I may have exhibited in other connections. You can't understand American industrial development without a far larger set of books on the history of petroleum than we now possess. You can't understand the well-fed appearance of today's Oklahomans without a knowledge of medical and public health history. In short, I commend history as a cultural channel complimentary to medical science, and perhaps indispensable to it.

COLLECTING ARCHIVES FOR THE HISTORY OF MEDICINE IN OKLAHOMA

M. L. WARDELL*

The problem of collecting archives in the field of medicine can be solved only with the cooperation of those persons now practicing medicine, the members of families who have in their possession files of those who have died, and any other persons who may have access to documents pertaining to medicine. The collecting of archives is always a cooperative program. Many letters, accounts, and libraries of the doctors in early Oklahoma will afford the background for a part of the history of medicine.

The Territory of Oklahoma dates from the opening to white settlement April 22, 1889. Legislation concerning medicine can not be found, of course, until the date of the meeting for the territorial legislature which was provided for in the Organic Act May 2, 1890.

During the early days of Oklahoma, the practice of medicine was, especially in the country, an example of sleepless hours, long drives, or trips on horseback. Since hospitals did not exist, there are, therefore, no early records assembled. The accounts of the heroism of both the doctors and the patients can be found only in diaries, reminiscences, and information from members of the doctors' families. To secure any written or printed documents one will have to communicate with and interview many persons who have in their possession the desired papers.

Doubtless many of the doctors found on the frontier came here to improve their health or the health of members of their families. Some of the doctors had reached the age of retirement and yet for reasons doubtless wished to experience a part of the frontier life. Such doctors were found both in the towns and in the country. Those who practiced through necessity in the country areas had to improvise "hospital facilities." The stories of such men can be found only by interviewing the few who are still living and who can relate some of these frontier experiences.

Much of Oklahoma's early history has been lost through fires, floods, dust, and carelessness. Too often many persons have no appreciation of "scraps of papers and old letters." Gaps in a community's history can sometimes be filled in with a single scrap of paper. Probably if the term "archives" could be used more often these fragments of history would be better preserved.

Letters from doctors in Oklahoma to their friends and relatives outside the state will furnish much personal information. What happened on a trip, in a country home, at a picnic, a "casual" shooting — all may be found somewhere in letters written to former associates. These letters are to be found in Kansas, Missouri, Ohio, Texas or Kentucky and other states. Those doctors who are now reaching the age of three score and ten can recall "old" doctors of 1900. Probably those old doctors' families, descendants of course, could be located and prevailed upon to search Uncle John's old desk for a letter of 1890, 1900 or 1910. Those letters make wonderful human interest stories.

It will take work and much more work to collect what is necessary for the history of medicine in Oklahoma but it can be done. Again it is cooperation and intensive concentration on the job that will make a wonderful historical narrative.

The Indian Territory has history in its missions founded more than 125 years ago. This can be found in certain archives. Medicine as practiced among the Indians—the Five Civilized Tribes — can be discovered. The soldiers in the forts, dating back to 1817, had to have medical attention. Some records exist that will help to fill in this period. What about the life on ranches in the Cherokee Outlet, life in the railroad camps and at trading posts? This part of the story must be found soon or part of our history of medicine will be completely lost.

The history of medicine is to be found in archives — letters, account books, prescriptions in drug stores, diaries, and in any and all written statements. Oklahoma Territory and Indian Territory afford a rich field of investigation.

*David Ross Boyd, Professor of History, University of Oklahoma.

President's Page

The 102nd Annual Meeting of the American Medical Association will convene in New York this month and it is fitting and proper that Oklahoma medicine recognize the tremendous impact the A. M. A. has had on the health of the American people.

Its Councils on Pharmacy and Chemistry, Food and Nutrition, Physical Medicine and Medical Education and Hospitals have all contributed to bring to the American people the highest standard of health care of any nation in the world. If further proof were needed to substantiate these comments, no greater proof would be necessary than the record that has been and is being made by scientific medicine and physicians in protecting the lives of our military forces.

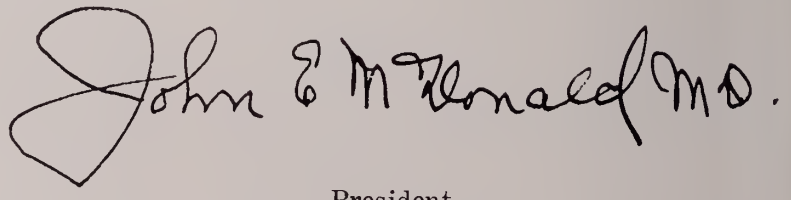
Over and above scientific medicine and medical education, we must not lose sight of the fact that of recent years the American Medical Association and its constituent State and Territorial Associations have entered into the fields of the social, economic and political problems of health.

The Delegates and Officers of the Oklahoma State Medical Association who will attend the A. M. A. will make every effort to give as great a consideration to these problems as has been given to scientific medicine and medical education by the A.M.A. for the past 100 years.

It it my opinion that unless these problems can be solved, the American public may stand to lose much of the advancements that have been made in scientific medicine and medical education.

The election of Mr. Eisenhower to the Presidency did not eradicate certain political and social ideologies and the do-gooders who are not fundamental in their approach to these problems, are still with us.

The House of Delegates of the A. M. A. must continue to be progressive but fundamental in its thinking as it considers medicine's place in the everyday life of the individual.



President

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CURRENT ACTIVITIES AT THE OKLAHOMA MEDICAL RESEARCH FOUNDATION

EDWARD C. REIFENSTEIN, JR., M.D.
DIRECTOR



The activities and problems of the nurses in the Oklahoma Medical Research Hospital form the basis of this article, the 18th in the current series. The Hospital received its first patient on September 2, 1952, and has been in operation for ten months.

During this interval, over 35 different persons have been admitted for periods varying from one day to more than seven months. A few patients have had several admissions for investigation. The Hospital census during the initial months was four to five patients, but since January of 1954, the number has been steadily increased until currently it varies between nine and 10 persons. These individuals have been admitted for studies in the fields of cancer, endocrine disturbances, metabolic bone disease, calcium metabolism and parathyroid abnormalities, and cardiovascular disorders.

The Director of Nursing, Miss S. Marian MacAulay, faced a major task in securing the initial complement of nurses in order that the Research Hospital could be opened for the admission of the first patient. It is necessary to secure graduate nurses for 24 hours a day, seven days a week, and to provide enough individuals to permit an eight-hour day, and a forty-hour week, as well as relief for illness and holidays.

Although it is the intention of the administrators of the Research Hospital to develop a permanent staff of trained nurses, there has been some turnover in nurses in an effort to secure the best qualified individuals for the special activities that are part of the investigative program. Miss MacAulay has spent considerable time training nurses of her staff in the special techniques of clinical investigation, particularly those involving metabolic balance studies, and in developing standardized nursing procedures. During this period, much of the hospital equipment was being received, and after 11 months, because of delays in delivery, certain special items still are not installed. All who have inspected the Research Hospital, however, have agreed that the equipment alread in use is unusually well-adapted for its purpose.

Because the patients stay much longer than in the usual hospital, the patient rooms have been made as much as possible like the bedrooms of a home. Gay, cheerful colors have been introduced whenever possible, with terra cotta, blue, and yellow beds and furniture, and with colorful drapes that harmonize with the other furnishings.

A recreation room has been provided. Here the patients spend their spare time enoying television, and participating in occupational therapy provided by volunteers from the Junior League of Oklahoma City, who come in two days a week. These women, Mrs. Todd Archbald, Mrs. Robert D. Gordon, Mrs. Guilford Hagmann, and Mrs. W. T. Milan, have taught the patients how to do textile painting, sewing, rug-making, leather work, and similar crafts which help to pass the unoccupied hours.

The nursing care in the Research Hospital requires exact attention to detail, an undertaking of the complete program, an ability to cooperate with all of the various technical personnel, and a facility for accepting new ideas in methods of treatment. The success of the Research Program depends vitally on the ability of the nurses to provide the best possible care, and to create an atmosphere that is relaxed and cheerful.

The nurses attend Grand Rounds with the clinical staff each Friday morning, and when possible they also attend the Research Staff Seminar which is given every Friday afternoon. The nurses assist with the cardiac catheterization procedures which are carried out each Tuesday morning. All surgery not requiring general anesthesia is done in the Treatment Room of the Research Hospital, which has been equipped as a minor operating room. Certain of the patients who have been on balance studies in the Hospital return after discharge as out-patients for follow-up visits so that further observations can be correlated with the data obtained from the studies during hospitalization. This gives the nurses an opportunity to see the long range progress of the patients.

Many of the nurses currently employed are either native Oklahomans, or have spent a considerable part of their training or professional careers in Oklahoma. To illustrate this, the background of these individuals will be briefly sketched.

Mrs. Virginia Young Cleator, R.N., although born in Beatrice, Nebraska, came to Oklahoma City when she was two months old. She was graduated from Classen High School, Oklahoma City, entered the Cadet Nursing Corps, attended Southwestern Tech in Weatherford, Oklahoma, and was graduated from the Wesley Hospital School of Nursing, Oklahoma City. In addition to nursing experience in Florida, she has worked at the University Crippled Children's Hospital, for Pontotoc County Health Department, Ada, Oklahoma, and for the Oklahoma Defense Blood Center. She joined the Research Hospital staff October 2, 1952.

Mrs. Sarah Robinson Hill, R.N., a native of Kentucky, came to Oklahoma in 1903. She completed high-school in Chickasha, attended college at Oklahoma City University, obtained teacher's training in Edmond, and received nurse's training at the Chickasha Hospital, at the Mercy Hospital in Kansas City, and at the Border and McGregor Hospital in Mangum, Oklahoma. In addition to private and staff nursing in many western states, she has nursed in a number of cities in Oklahoma, and at most of the hospitals in Oklahoma City. She joined the Research Hospital staff in December, 1952.

Mrs. Vinita Waston, R.N., was born in Anadarko, Oklahoma, was graduated from St. Anthony Hospital, Oklahoma City. She has worked as a private office nurse, and as an assistant supervisor at the Bone and Joint Hospital, Oklahoma City. She joined the Research Hospital Staff on April 1, 1953.

Mrs. Nellie Phariss, R.N., born in Crescent, Oklahoma, was graduated from the University of Oklahoma School of Nursing, and worked there for several years. She is a relief nurse.

Miss LeVae George, R.N., born in Berryville, Ar-

(Continued on Page 165)

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Deucher, F.: Schweiz. med. Wchnschr. *82*:1 (Jan. 5) 1952.

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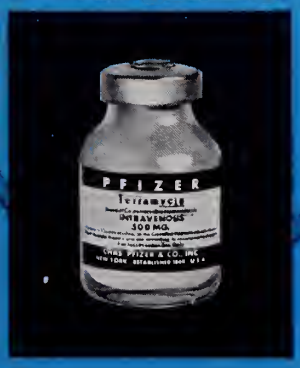
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Farley, W. J., Konieczny, L.: J. Pediat. *42*:177 (Feb.) 1953.

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Reiss, E., et al.: A. M. A. Arch. Surg. *64*:5 (Jan.) 1952.

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NARCOTICS, MENTAL HOSPITAL INVESTIGATING COMMITTEES NAMED

By authorization of the Council in special session in Tulsa April 14, two committees of the Association were named to work with committees of the Legislature.

Appointed to the committee to work with the House of Representatives investigation committee on the preparation of legislation aimed at providing better control of narcotics and barbiturates were Fay Lester, M.D., Oklahoma City, chairman; William T. Gill, M.D., Ada; and H. A. Shoemaker, Ph.D., Oklahoma City.

Appointed to the committee to investigate Central State Hospital, Norman, were J. Hoyle Carlock, M.D., Ardmore, Chairman; Joe Tyler, M.D., Tulsa; and Maud Masterson, M.D., Oklahoma City.

The narcotics committee is now at work and has already spent many hours in meetings with the House of Representatives committee and with representatives of the other professional groups which would be affected by any such legislation. The committee has made a preliminary report to the Council at a special meeting April 28. The council authorized the committee to continue its work and report back at a later date to the Executive Committee of the Council.

Members of the Committee investigating Central State Hospital made a personal investigation at the hospital and their report, which had not been released for publication at Journal press time, has been made directly to the Central State Hospital investigating committee of the Legislature.

MEETING DATES SET FOR '54

Dates have been set for the 1954 Annual Meeting of the Oklahoma State Medical Association, which is to be held in Oklahoma City May 10, 11, and 12. House of Delegates will convene Sunday, May 9. Scientific sessions will be held in the Municipal Auditorium, the meeting site of the last two annual meetings held in Oklahoma City.

TO ATTEND A.M.A.

Official representatives of the Oklahoma State Medical Association to the A.M.A. to be held in New York City June 1-5 will be: John E. McDonald, M.D., Tulsa, President; John F. Burton, M.D., Oklahoma City, Delegate; James Stevenson, M.D., Tulsa, Delegate; Malcom Phelps, M.D., El Reno, Alternate Delegate; and John K. Hart, Associate Executive Secretary.

1953 Meeting Largest on Record

The 1953 Annual Meeting held in Tulsa April 13, 14 and 15 had the largest attendance of any previous meeting. Attendance totaled more than 900. The scientific program was well received and it was considered among the best annual meetings of the Association. Bruce Hinson, M.D., Enid, was named president-elect at the House of Delegates. John E. McDonald, M.D., Tulsa, is the new president.

HONORARY FRATERNITY ESTABLISHED AT O. U. MEDICAL SCHOOL

Twenty-six men were initiated as charter members of the University of Oklahoma School of Medicine chapter of Alpha Omega Alpha, honorary medical society, on May 1 at the Oklahoma Club.

Dr. Walter L. Herring, national president of Alpha Omega Alpha, conferred the charter of Alpha Chapter of Oklahoma and Dr. Josiah J. Moore, national secretary-treasurer, presented the keys and certificates.

Local alumni groups have applied for an Oklahoma chapter for several years. There are now more than 50 active chapters of Alpha Omega Alpha, which is considered the Phi Beta Kappa of medical schools.

Dr. William B. Bean, Head of the Department of Internal Medicine at the State University of Iowa College of Medicine, delivered the installation address, "Caritas Medici." Dean Mark R. Everett was master of ceremonies at the installation.

Others taking part in the program were: Dr. George L. Cross, president of the University of Oklahoma; Thomas R. Benedum, president of the board of regents of the University of Oklahoma; Dr. Peter E. Russo, chairman of the Department of Radiology at the University of Oklahoma School of Medicine, and William F. Denny, senior medical student at the School of Medicine.

Charter members in the new chapter are:

Faculty Initiates: Robert H. Bayley, M.D.; Harrell C. Dodson Jr., M.D.; Arthur A. Hellbaum, Ph.D., M.D.; Howard C. Hopps, M.D.; Lewis J. Moorman, M.D., and Stewart G. Wolf, Jr., M.D.

Honorary Alumnus Initiate: Class of 1913—Robert H. Riley, M. D.

Graduate and Student Initiates: Class of 1952—Lynn C. Barnes Jr., M.D., Miami; James P. Bell, M.D., Tecumseh; Leo P. Cawley, M.D., Drumright; Joe C. Horton, M.D., Hollis; James L. McGovern, M.D., Wewoka, and John M. Moore, M.D., Ada.

Class of 1953—Charles W. Cathey, Ardmore; William F. Denny, Guthrie; Allen B. Eddington, Tulsa; Raymond L. Engles, Durant; Benjamin H. Moore, Jr., Oklahoma City; William L. Morgan, Tulsa; Donald J. Sheffel, Tulsa; Carl W. Smith, Jr., Enid; Robert M. Stover, Miami, and Richard L. Winters, Stringtown.

Class of 1954—Boyd K. Lester, Rush Springs; John M. Massey, Oklahoma City, and Roscoe R. Robinson, Enid.

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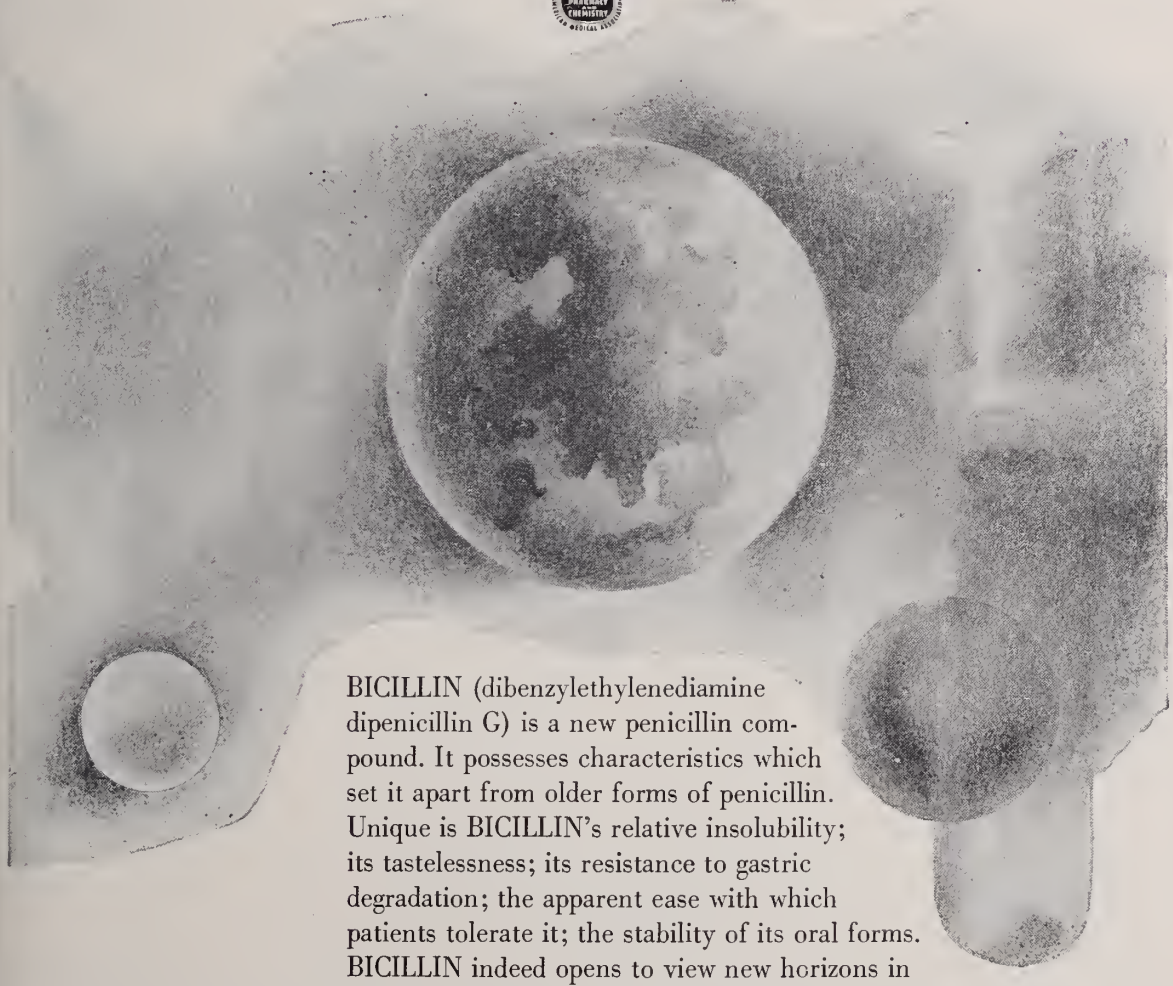
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HAVE YOU HEARD?

William J. Trainor, M.D., Tulsa was honored recently at an "appreciation dinner" given by the medical staff of Hillcrest Hospital.

Neeson Rolle, M.D., who has practiced in Seiling and Fort Supply, Okla. for the past five years, has returned to Poteau to practice.

C. A. McBurney, M.D., Clinton, recently gave that city two lots with the understanding that a library would be built on the site.

Harry Hall, M.D., Boise City, has returned from a two months trip to eastern states.

Melvin Hicks, M.D. has recently been released from service and is practicing in Ada. He is also Pontotoc County Health Officer.

L. E. Gee, M.D., Broken Bow, was recently honored by the Lions Club of that city for his 52 years of community service.

A. M. Evans, M.D., Perry, is constructing a new five room office building.

F. L. Flack, M.D., Tulsa, was recently featured in a newspaper article citing his volunteer work in surgery at Moton Memorial Hospital for Negroes in Tulsa.

E. Rankin Denny, M.D., formerly of Tulsa, has opened his offices in Nowata.

Robert E. Dean, M.D., and *Eugene C. Bond, M.D.*, Fairfax, have entered the Air Force and are stationed at Gunter Air Force Base, Montgomery, Alabama.

J. Paul Jones, M.D., Dill City, was honored with a special celebration and gifts including a television set on the occasion of his 87th birthday.

SEVENTY-ONE RECEIVE FIRST CHOICE OF INTERNSHIPS

Among all the medical schools in the United States, the students at the University of Oklahoma obtained the largest number of first choices in the internship appointments for next year according to Stewart Wolf, M.D., Professor and Head of the Department of Medicine at the school.

Fourth year students from all of the medical schools in the United States apply to the hospitals of their choice for internship. The hospitals, in turn, had a designated date to send to a central office in Chicago their selection of prospective interns in order of preference. This list was then matched with the preferences of the prospective interns.

Seventy-eight students are in the University of Oklahoma School of Medicine senior class and of this number, 71 achieved their first choice of hospital. Five received their second choice and the remaining two their third choice.

AMA MEETING TO BE AIRED ON RADIO AND TV

Physicians who cannot attend the AMA's 102 annual convention can see and hear highlights of the meeting via radio and television.

The presidential inaugural ceremony will be broadcast coast to coast on Wednesday, June 3. Although the inauguration of President-Elect Edward J. McCormick will be held Tuesday, the coronation of Queen Elizabeth II of England on the same day—which will be widely covered by radio and television—has made it necessary to re-broadcast the proceedings on Wednesday evening.

In television areas, the half-hour "March of Medicine" program, originating at the Scientific Exhibit in New York's Grand Central Palace, will be presented either Thursday or Friday evening. This television coverage will be sponsored by Smith, Kline and French, Philadelphia pharmaceutical firm.

ON ACTIVE DUTY

Oklahoma physicians who recently have entered service include the following:

Robert L. Anderson, Tulsa, army
James O. Asher, (Maj.), Altus, air force
Eugene C. Bond, (Lt.), Fairfax, air force
Clifford Alton Brown, (Capt.), Oklahoma City, army
Gerald E. Cronk, (Capt.), army
Wallace N. Davidson, Jr., (Lt.), Cushing, air force
Robert E. Dean, (Lt.), Fairfax, air force
Joseph B. Dixon, (Capt.), Bartlesville, army
Raymond J. Dougherty, Jr., (Lt.), Perry, army
Charles L. Freede, (Capt), Oklahoma City, army
Robert W. Gibson, (Lt.), Ponca City, air force
Robert H. Hayne, (Maj.), Tulsa, army
William N. Henderson, (Capt.), Tulsa, army
Thomas D. Howard, (Lt.), Chelsea, air force
Maxwell A. Johnson, (Capt.), Tulsa, air force
A. M. Josephson, (Lt.), army
William F. LaFon, (Maj.), Alva, air force
Otis S. Lee, (Maj.), Tulsa, army
Leon Marder, (Capt.), air force
Paul J. Ottis, (Capt.), Okarche, air force
Irvin D. Palm, (Capt.), Tulsa, air force
Nolan C. Riley, (Capt.), Tulsa, army

RELEASED FROM SERVICE

Physicians recently released from service and not previously reported in the Journal are:

Richard E. Carpenter, Oklahoma City
Melvin C. Hicks
Robert P. Holt, Oklahoma City.

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BOOK REVIEWS

FUNDAMENTALS OF CLINICAL ORTHOPEDICS. Peter A. Casagrande and Harold M. Frost, Jr. Grune and Stratton, 1953.

There have been in the last few years, several orthopedic testbooks directed toward the various sections of the medical populace, but none better suited for the general practitioner or medical student than this most recent publication by Casagrande and Frost. The authors have made no effort to explore all the new and experimental methods and highly specialized techniques in orthopedic surgery, and to this extent, the book may be somewhat disappointing to the practicing orthopedist. However, they have accomplished their aim of enlightening the medical man, whose interest in orthopedics is something less than that of the orthopedic specialist. The subject is as well covered as can be expected in a single volume covering the whole field of orthopedic and fracture surgery. The book is divided into eight sections, opening with a section on basic science which is particularly good, including rather brief discussions of metabolism, the various systems, micro-biology, anesthesia, and associated operative complications, such as fat embolism shock, etc. They give some discussion as to the function of the various joints; a brief description, but lucid one, of bone union; and the advantages and limitations of bone grafting; ending with a concise description of some of the "dos" and "don'ts" in the use of plaster of paris. In the clinical section of the book, the authors have made a definite effort to mention, if but briefly, all of the many various things which may confront the busy practitioner. Their section on congenital conditions is, I think, particularly inclusive. It may be that the authors err somewhat in mentioning all the uncommon deformities while keeping the more common ones unnecessarily brief. However, the practitioner has at his disposal in the literature many references for the common diseases, but may have a great deal of difficulty in finding any reference at all to some of the more unusual conditions with which he may be confronted.

The section on tumors and allied disorders is, I think, too brief to be of any real diagnostic value. However, most of the tumors are mentioned and, thus, the practitioner can be put on the track of whatever group of tumors he may be encountering. There are, of course, many excellent text books on tumors of bone which are readily available. The same criticism would apply to some extent to the section on trauma, but again, the same observation may be made, namely, that there are a multitude of good books on trauma which are readily available, and obviously, all types of injury cannot be included in a text as all inclusive as this one. The last section, Section 8, on amputation, prostheses, braces, shoes, and shoe corrections, is unusually valuable to the student and is usually omitted from a text of this type.

In resume, therefore I would say that this book presents a very distinct addition to the armamentarium of the medical student and medical practitioner interested in treatment of orthopedic and traumatic affections.—Don H. O'Donoghue, M.D.

LEONARDO DA VINCI; On the Human Body. The Anatomical, Physiological and Embryological Drawings of Leonardo da Vinci with Translations, Emendations and a Biographical Introduction. Charles D. O'Malley and J. B. de C. M. Saunders. Henry Schuman, Inc. New York, 152. 215 plates. $25.00.

Leonardo da Vinci, a genius of many talents has not

been widely known as an anatomist but certainly all who pursue this volume cannot help but agree with the compilers that "Leonardo da Vinci represents the greatest heights reached by the artist anatomist." The artistry alone is rewarding enough. In addition, for the physician who will take the time to read Leonardo's text and the annotations of Drs. O'Malley and Saunders, there is unfolded a fascinating story of Leonardo the anatomist and of 16th century medical knowledge.

Henry Schuman has published another outstanding reproduction of a medical masterpiece. The introduction, biography and annotations of the compilers are in and of themselves of considerable interest. They are clear and represent a labor of love.

The reproductions are superbly done. The richness of the volume is in keeping with its contents. It is a volume that will afford many hours of enjoyment to physicians with any interest in the origins and development of their profession and would be an ornament to any library.—John P. Colmore, M.D.

PRESENT PAPERS IN KANSAS

Several Oklahoma physicians recently presented papers in Kansas at the Metabolism and Endocrinology postgraduate course at the University of Kansas and at the Mid-Continent Psychiatric Association Program.

Henry H. Turner, M.D., Oklahoma City gave three papers at the post graduate course on "Thyroid Hypofunction and Thyroid in Treatment," "Medical Management of Thyrotoxicosis," and "Ovarian Hypofunction." A paper on "Post-Menopausal Osteoporosis and Related Disorders" was presented at the University of Kansas by Edward C. Reifenstein, M.D., Oklahoma City.

At the Mid-Continent Psychiatric Association, Doctor Turner spoke on "Psychosomatics and Pseudoendocrinopathies." Two other Oklahoma physicians delivered papers. They were "The Significance of Helplessness in Personality Disorders," Muriel Hyroop, M.D., and "A Psychiatric Study of 300 Antabuse Patients," Moorman P. Prosser, M.D., Oklahoma City.

CURRENT ACTIVITIES

(Continued from Page 158)

kansas, was graduated from the Oklahoma Baptist University with a Bachelor of Music degree, and was graduated as a nurse from the Baptist Memorial Hospital in Memphis, Tennessee. She is a relief nurse.

Mrs. Mary Billings, R.N., a native of Nanticake, Pennsylvania, was graduated from Mercy Hospital, Wilkes-Barre, Pennsylvania. She worked in the Army Air Corps during World War II. She also is a relief nurse.

Mrs. Ginna Nichols, R.N., was born in St. Louis, Missouri, was graduated from St. Luke's Hospital School of Nursing, St. Louis, and then worked as an operating room nurse. In November, 1952, she came to Oklahoma City. She learned about the Research Hospital from television broadcasts, and joined the staff in January, 1953.

The nurses of the Research Hospital are vital members of the scientific team, and must meet the most rigid standards in order for the research program to succeed. Those already on the staff find their activities most interesting and are eager to continue. There is a critical need, however, for additional nurses. Any nurse who is a graduate of a recognized school of nursing, and who is interested in furthering the progress of medical science by serving in the Research Hospital should contact Miss S. Marian MacAulay, the Director of Nursing.

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EXPLANATION GIVEN ON PARTNERSHIP LIABILITY

As a result of a number of inquiries from members of the profession in regard to the coverage afforded by their malpractice insurance policies in partnership situations, the legal opinion reprinted below was prepared by the firm of Grigsby, Foliart and Hunt and directed to Mr. Roger Bainbridge, the adjuster for the St. Paul Mercury Indemnity Company, which carries the Association's master policy. It is hoped that this opinion will clarify this question for members of the Association.

"In our discussion the other day, you asked our opinion concerning the liability of a doctor who is a partner in a partnership operating a hospital in which an employee negligently injures a patient.

"The most important fact concerning a doctor's individual liability is that a partnership in the state of Oklahoma is a legal entity. Holmes v. Alexander, 152 P. 819; Hessen v. Roger, 253 P. 72. As a legal entity it is liable in damages for the negligent acts of its employees and agents. A general partner is an agent of the partnership whenever he is acting within the scope of his authority. 54 O.S.A. 33; Anderson v. Whitner, 261 P. 156.

"A partner that is acting for the partnership is liable in his own behalf for a tortious act as an agent is always liable for his own tortious act done in furtherance of his principal business. Thus a partner can be sued personally and the partnership can be joined as a co-defendant in the same lawsuit. Right Away Laundry v. Davis, 225 P. 345. But where a partnership is sued alone for the acts of the partnership's employee, the individual partners are not personally liable, but liable only to the extent that they have an equity in the partnership's property and assets which will be used to satisfy any judgment rendered against the partnership. If the individual partners are served with summons when the partnership is sued, then the individual partner may have his own personal property taken to satisfy the judgment rendered against the partnership after the partnership assets have been exhausted, but only if the individual partner is served. A partner need not be served to have his equity in the partnership assets taken to satisfy the judgment against the partnership. Bearman v. Bracken, 240 P. 713; Sprangenberg v. Galena Perforating Co., 218 P. 804. The case of Fowler v. Brooks, 146 P. 2d 304, states the law as to the personal liability of a partner as follows:

> "'Partners as such are not directly or personally liable on debt or liability of partnership, and their liability arises out of their connection with firm and traceable only through a firm and must be established by judgment against firm, and no personal judgment may be entered against partner as such but his property may be subjected to payment of partnership liability when assets of partnership are insufficient to pay its obligations.'

"In conclusion it can be stated that if a doctor is not personally liable due to his own negligence and that of his own personal employees, the acts of an employee of the partnership will not make the doctor personally liable, and the doctor can have all of his equity in the partnership assets taken to satisfy the judgment against the partnership, and may have his own personal property taken to satisfy an excess judgment over the assets of the partnership only where the doctor as a partner has been personally served with a summons. Any loss to the doctor caused by a judgment rendered against the partnership over and beyond the partnership's assets does not come under the coverage of the doctor's persoual liability insurance policy. To prevent this loss a doctor should insure his partnership in such an amount that would satisfy any judgment rendered against it. Thus, in order for a doctor as a partner and as an individual to be fully protected against liability, he must have an insurance policy on the partnership and one on himself."

OBITUARIES

J. SCOTT CHALMERS, M.D.
1895-1953

J. S. Chalmers, M.D., Sand Springs, died March 22 in a Tulsa hospital following a two-day illness.

A general practitioner, he specialized in industrial surgery. He was born in Chicago in 1895 and graduated from the University of Virginia medical school. He practiced one year in Ada before moving to Sand Springs.

Doctor Chalmers was a member of the International College of Surgeons, Independent Medical Association, Southern Medical, Dallas Southern Clinical Society, A. M. A. and other medical organizations. He was active in civic affairs and was president of the Lions club and member of the chamber of commerce and American Legion.

Survivors include his widow of the home, three sons, his mother, four sisters and six grandchildren.

H. LEE FARRIS, M.D.
1876-1953

H. Lee Farris, M.D., pioneer Tulsa physician, died April 10 in a Tulsa hospital.

Doctor Farris, who had resided in Tulsa since 1922, headed the medical staff at Douglas Aircraft Co. since 1951, having held a similar position there during World War II.

Doctor Farris was born in London, Kentucky and studied medicine at the University of Louisville and was graduated from the Medico-Chirugical College of Philadelphia in 1900. He practiced at Memphis, Tenn. and Paris, Texas, prior to coming to Tulsa. In addition to his medical activities, he was a member of the Knife and Fork Club.

Survivors are his widow, one son and two brothers.

J. T. B. WIDNEY, M.D.
1878-1953

J. T. B. Widney, M.D., who until one year ago, lived at Kaw City, died April 5, in Fresno, Calif.

Doctor Widney was born October 9, 1878 at Burnt Cabins, Pennsylvania. He received his medical education at Washington University in St. Louis, Missouri, and came to Ponca City about 1900 where he entered practice with his brother. Later, when Kaw City was established, he moved there and practiced for 50 years.

THE JOURNAL
of the
OKLAHOMA STATE MEDICAL ASSOCIATION

EDITORIALS

THE ENFORCEMENT OF LAW

For those people concerned with the enforcement of the statutes there is a never-ending effort and a continuous frustration. Many citizens who are otherwise very responsible concern themselves only with law enforcement, asking "Why is the law not enforced?" The same citizen often being asked to assist in securing evidence will have no part of it. The people who are in contempt of the law are not interested. The enforcement of the law therefore is reflected in the formula which may be represented as the desire of the citizens that the law shall be enforced as compared with the relative indifference of the citizens to law enforcement.

There are certain people who feel that the penalties for violations should be increased. It might be more effective if the interest in enforcement could be increased. Enforcement of the law eventually reflects the degree of desire made effective by the people of the state. The unlimited power to enforce should never be vested in any one individual or group of individuals, however representative of public opinion. These principles apply to the enforcement of narcotic regulations and others. The will to make laws operative and effective is in the same category as the desire to preserve the freedoms.

Methods should include more emphasis on interest at the local (as for instance, county) level, less upon coercive legislation.—Clinton Gallaher, M.D.

HAVE A GOOD TIME

Everybody takes a vacation except the Editor-in-Chief and the Editorial Assistant. It takes two heads and a lot of hands to get the July and August issues of the *Journal* off the press and on the way to your address. These issues of the *Journal* may remain unread but they are important. They put us on record and preserve the historical continuity of the Association. We crave no credit that posterity cannot supply. But we would like for you to think of us as you contemplate the halcyon depths of your favorite fishing hole or the cool embrace of *aqua pura* in your fashionable swimming pool.

Let not this lament curb your abandon.

THE ROAD TO SURVIVAL AND HUMAN DESTINY

These phases of our earthy existence supply not only something to think on and to write about but an imperious demand for action. In this new and uncertain age with its uneasy socio-economic conditions, its incessant war psychology with an uncertain tenure of life for those in the productive period of their existence, there is an unprecedented challenge for all bonafide Americans.

With medical accomplishment at its zenith contending with death as never before, often forcing Father Time to sheathe his scythe,thus increasing average longevity and pyramiding the old age group, medicine is faced not only with the pathological, clinical and therapeutic problems of the aged but in the light of the above socio-economic conditions, the accepted and overworked retirement age and the hazards of war with their exacting demands, the medical profession cannot escape the increasing need of adequate, comfortable, cheerful domiciliary provisions for the unfortunate aged who for various reasons cannot have satisfactory home care.

All this serves only as an introduction to my appeal that every member of the State Medical Association read the "New Plan for the Care of the Aged and Infirm" printed in the May 2 *J.A.M.A.*, Vol. 152, No. 1, Page 76, 1953. Here is the sad story strikingly told with the promise of a workable plan. This appeal comes from Russell I. Garton, M.S., in charge of the Medical Department of Oxford University Press. The author, while not an M.D., has worked throughout the years with the best medical minds trying to put logical and scientific facts into print.

Apparently his training, his experience and his knowledge of the need are back of this well laid plan.

The challenge to the medical profession cannot be ignored. Here is a plan well worth serious consideration. Recover your *A.M.A. Journal* of May 2 and read or re-read this story. It deals with a problem which must ultimately reach the mind and heart of every true physician.

MORBID CURIOSITY MET BY MEDICAL KNOWLEDGE

In view of the avid interest in recent publicity about Christine, physicians who are not already fully informed should read the article on "Transvestism, Hormonal, Psychiatric, and Surgical Treatment" by Christian Hamburger, M.D., Copenhagen, Georg K. Sturup, M.D., Herstedvester, and E. Dahl-Iversen, M.D., Copenhagen, Denmark.

This interesting discussion of a rare condition appears in the *J.A.M.A.* of May 30, 1953. The authors define the terms Divestism and eonism and discuss the unaccountable desire to be a female and an obsessive urge to wear women's clothes. They discuss the possible origin of "genuine transvestism" or "psychic hermaphrodism," its symptoms, physical and psychological aspects, social and sexual implications and the medical profession's responsibilities.

The article is interesting and well worth the reading because of knowledge it contains.

HOW SOON WE FORGET

It was characteristic of our own Lea A. Riely, M.D., now of New Canaan, Conn. to appear at the New York A.M.A. meeting and alert the press to the fact that the American Medical Association met in the Bleecker Street Presbyterian Church in New York City May 5, 1853, and that Oliver Wendell Holmes celebrated the occasion by writing a poem about the meeting. Our members will be glad to know that Lea was in attendance at the 1953 meeting emanating erudition, informing reporters and embarrassing some of the old timers who should have made use of the these facts for pre-convention publicity. "The past is prologue" whether we know it or not.

It is well known that Doctor Riely gave up his practice in order to catch up with his reading. He is not idle. His rating among the highbrows of New Canaan is such that his name is the postman's guide—no street address required.

MEET OUR CONTRIBUTORS

William Benzing, Jr., M.D., Tulsa, is the author of "Wilms' Tumors of Infancy and Childhood" in this issue of the *Journal*. Dr. Benzing was graduated from Rush Medical College in 1936 and interned at Kansas City General Hospital. He served residence in pathology, radiology and surgery. A member of the American College of Radiology, he has been certified by the Board. He served 43 months in the Air Force in World War II and was a captain at the time he was released. He practiced in Hamilton, Ohio, before coming to Tulsa.

Allan Bloxsom, M.D., Houston, Texas, wrote "The Use of a Pan-Transfusion System" in the July issue. Doctor Bloxsom is a clinical associate professor of pediatrics at the University of Texas Medical School and associate professor of clinical pediatrics, Baylor University Medical College. He graduated from Rice Institute with a B.A. in 1923 and received his medical degree from Johns Hopkins in 1927. He is a diplomate of the American Board of Pediatrics and a fellow of the American Academy of Pediatrics.

Francis J. Braceland, M.D., Sc.D., Hartford, Conn., a guest speaker at the 1953 Annual Meeting, and *William W. Zeller, M.D.*, Philadelphia, Penna., are joint authors of "Middle Life and Mental Disease." Doctor Braceland is psychiatrist-in-chief at the Institute of Living and clinical professor of psychiatry, Yale University School of Medicine. He is president of the American Board of Psychiatry and Neurology and was formerly dean of Loyola University School of Medicine. He was chief psychiatrist, USN, 1942-46 and was chief of the section on psychiatry, Mayo Clinic, 1946-51. He was graduated from Jefferson Medical College. Doctor Zeller was recently graduated from George Washington University and was also with the Mayo Clinic until recently.

Walter A. Fansler, M.D., Minneapolis, Minn., a guest speaker at the 1952 Annual Meeting, has an article on "Choice of Operation in Carcinoma of Rectum and Rectosigmoid" in the July *Journal*. Doctor Fansler received his B.A. from the University of Missouri and his M.D. from Johns Hopkins University. He previously has served as instructor in pathology at Marquette University, clinical professor of surgery at the University of Minnesota, consulting surgeon at the Minneapolis General Hospital and a member of the active staff of several other hospitals of that city and consulting proctologist at Glenn Lake Sanatorium, Minneapolis. He is a fellow of the American College of Surgeons and the American Proctologic Society and a member of the American Board of Proctology, Minneapolis Academy of Medicine and served as president of the American Proctologic Society.

Scientific Articles

THE USE OF PAN-TRANSFUSION SYSTEM*

ALLAN BLOXSOM, M.D.

HOUSTON, TEXAS

Following the discovery of the blood groups by Landsteiner[1] in 1901, and the Rh factor by Landsteiner and Wiener[2] in 1937, blood transfusions have increased tremendously in number. In fact the increase has been so great that a recent report[3] calls attention to the medical problems created by our large national blood program.

Unique also is the fact that in spite of the great increase in the number of blood transfusions, the method almost entirely used is the one way blood transfer. The one exception of replacement transfer of blood in erythroblastosis fetalis remains today the only variant choice of transfer of blood in our methods of therapy. A search of the literature reveals no pan - (all purpose) transfusion system to handle the various methods of blood transfers. The use of a reciprocal blood transfer in hemophilia and a replacement blood transfer in nephrosis will be reported in this study. A review of the literature does not reveal the use of this therapy in either condition.

The ideal pan-transfusion system must be capable of accomplishing (a) reciprocal blood transfers, (b) replacement blood transfers, (c) one way blood transfers, and (d) exsanguino-medicated blood transfers. In addition all the following requirements must be met. First. Blood can be exchanged at the rate of 0.5 to 5 liters per hour. Second. No appreciable hemolysis with chemical changes capable of causing reactions can be permitted. Third. Accurate measurements must be made on transferred blood. Fourth. Automatic equalization of amounts of blood transferred in both directions. Fifth. Venous blood should be used in order not to sacrifice arteries with each blood transfer.

* Presented before the General Session at the Annual Meeting of the Oklahoma State Medical Association, April 14, 1953.

Apparatus

The present pan-transfusion system, consisting of two evenly matched 20 cc lubricated syringes mounted in a rack, and connected through two three way stop cocks inverted with regard to each other and operated by a common handle, with "Y" shaped plastic harnesses and air traps with the bases of the "Y" connected with the veins of the recipient and donor or a waste receptacle, fulfills all of the above requirements for the various methods of blood transfers. The plastic harnesses are expendable.

Report of Cases

The use of reciprocal blood transfers has been noted chiefly in the Italian and French literature[4,5] with an occasional reference in the American literature.[6] Reciprocal blood transfers may be used in

a. Hemophilia.
b. Anuria (temporary) due to
    1. Mercury poisoning
    2. Sulfonamides.
    3. Scarlet fever
c. Hypertension
d. Nephrosis associated with an anuria.
e. Toxemias of pregnancy.

CASE REPORT: Carlos B., a three-year-old white male was admitted to the St. Joseph's Infirmary in Houston, Texas on January 18, 1953 the parents stating a profuse hemorrhage had developed in the nose that morning and they were unable to stop the bleeding. The child is a known hemophiliac and has received numerous transfusions in different hospitals. In addition he has a cousin who is a hemophiliac.

Physical examination revealed a well developed, irritable white male child bleeding rather profusely from the nose. The skin showed a number of ecchymotic areas over both lower extremeties. The abdomen was prominent and the liver palpable under the costal margin. On admission to the hospital the child's hemoglobin was 10.5 gms, red blood count, 3,850,000 and white blood count 6,400. The differential showed 64 per cent small lymphocytes, two per cent eosinophiles, and 34 per cent neutrophiles. He was type A, Rh÷. The coagulation time was 21 minutes. Fifteen days previously the coagulation time was over one hour. At this time he was given a small direct transfusion of 300 cc which had to be discontinued when a marked urticarial reaction developed.

In preparation for the present transfusion the patient was given one grain nembutal suppository, one teaspoonful of elixir of Benadryl, 25 mgm of Dramamine and 25 mgm of cortisone. The father (donor) was given two teaspoonsful of elixir of Benadryl, 50 mgm of Dramamine and 50 mgm of cortisone. At the time of transfusion the child had to be given an intravenous anesthetic because of the difficulty in keeping him still.

A polyethylene catheter was inserted into the saphenous vein in the upper thigh and carefully threaded into the femoral vein to the external iliac and then into the inferior vena cava. A good flow of blood was obtained. The father (donor) was given 2 mgm of heparin per kilogram of body weight. After 10 minutes a #16 needle was inserted through an anesthesized area of the arm into the basilic vein. The pan-transfusion system as set up in Figure 1 was then connected to the needle in the donor's arm vein and the polyethylene catheter in the patient's vein and the reciprocal blood transfer started. Over a period of one hour 1000 cc were given.

At the end of 1000 cc it was noticed that the bleeding from the nose had ceased and there was no bleeding from the skin incision that had been made in the thigh to insert the polyethylene catheter into the vena cava. The transfusion was discontinued and the patient returned to his room.

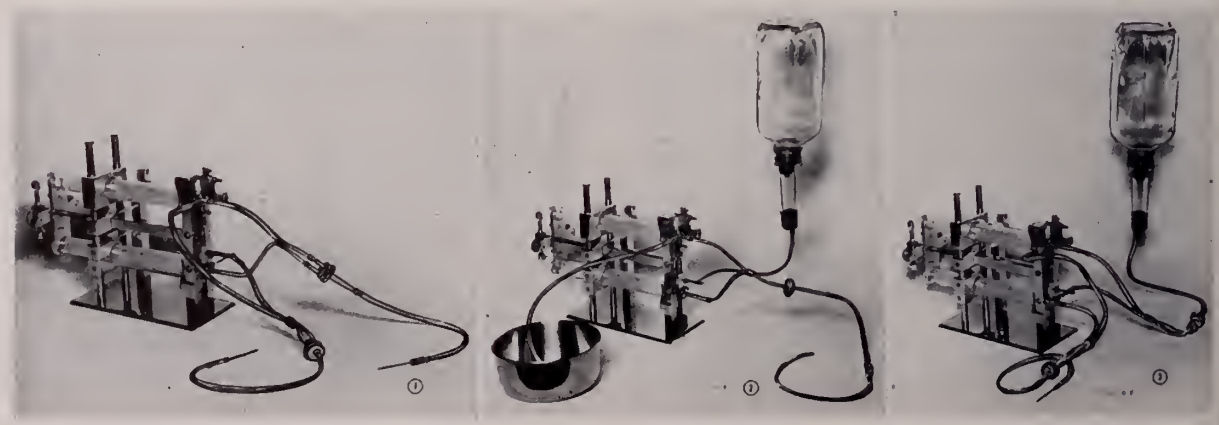
The following day the clotting time was five minutes. Eight days later the coagulation time was eight minutes. Twelve days after transfusion the coagulation time was seven minutes 15 seconds. Twenty days after the transfusion the coagulation time rose to 18 minutes. There had been no further bleeding from the nose and the skin incision in the thigh had healed. This case report will be given in full later.

One is impressed that no mention is made in the literature of the possible value of reciprocal blood transfers in the control of hemophilia. Here is one condition that should be ideally treated and well controlled by reciprocal blood transfers.

Replacement of blood transfers have been used in

a. Erythroblastosis fetalis[7,8,9,10]
b. Leukemia[11]
c. Nephrosis
d. Transfusions reactions.

CASE REPORT of Replacement Blood Transfusion in Nephrosis: Joan H. a two-year-old white female with nephrosis was admitted to the St. Joseph's Infirmary in Houston, Texas, anuric for 30 hours and in cardiac failure. On two previous admissions she had been treated with ACTH with good results, but on the third admission and treatment with ACTH she almost died. It was believed that a replacement transfusion might benefit this patient and she was given a replacement blood transfer of 2000 cc. Voiding started shortly afterwards and over a period of three weeks this child lost seven



pounds and was sent to her home. At a later date she was re-admitted to the hospital and an abdominal paracentesis done. A remission then occurred and she lost 10 more pounds. Today except for a faint trace of albumin in the urine she apears to be well. The pan-transfusion system as set up in Figure 2 was used for this child.

One way blood transfers have been used in a large number of conditions and indications of the need of this type of blood transfer are well known as it accounts for more than 99 per cent of the present day blood transfers.

Discussion

It is interesting to note that the first physicians who tried transfusions in the seventeenth century started by doing replacement blood transfers. Eutyphronus stated, "It is foolish to transfuse a patient without previous blood letting, because this would not reduce the strain on the body." Diamond[10] in 1948 wrote that "20 cc exchanges do not upset the infant's circulation to any extent that we have noticed." The 20 cc exchange on the patient with nephrosis and cardiac failure placed no additional burden on the circulation that could be noticed.

The rate of transfer of blood per hour with the dual matched 20 cc syringes in the present blood transfer system depends upon the size of the needles used and the size of the polyethylene catheter. The following table gives the rates possible with the different sizes of needles and plastic catheters.

Needle Guage #16	4800 cc per hr.
Polyethylene tubing (.064)	4800 cc per hr.
Polyethylene tubing (.028)	2400 cc per hr.

The following table gives the percentages of the patients' blood replaced in terms of volumes of blood given.

Amount of Blood given in volumes of patient's blood	*Percentage of Patient's blood Replaced*
One-half	39.4 per cent
One	63.2 per cent
One and One-Half	77.7 per cent
Two	86.5 per cent
Two and One-half	91.8 per cent
Three	95.0 per cent

It is always important to use fresh blood. Potassium (normal level in blood 5 to 8 mEq. per liter) passes from the erythrocytes to the plasma during storage. Bank blood that has been in storage up to 48 hours may be used. Five per cent calcium gluconate in 2 cc amounts should be administered intravenously for every 100 cc of blood used in replacement blood transfers. Evidence of hypocalcemia is evidenced by a prolonged QT interval and a lengthened ST segment. In severe hypocalcemia heart block may appear.

The reasons for replacement blood transfers in erythroblastosis fetalis are

1. Removal of the infant's coated or potentially destructible Rh-positive red blood cells as completely as possible.

2. Removal of antibodies in infant's circulation.

3. Removal of as much blood pigment in circulation as possible.

Hsia, Allen, Diamond, and Gellis[12] state that the serum bilirubin level provides the most acurate guide in whether to replace or not replace the erythroblastotic infant's blood. In a series of 229 infants with erythroblastosis fetalis[10] reported recently they state that the majority of those sensitized infants had cord bilirubin levels of 5 mgm per 100 ml though visible jaundice was not present at birth. Thereafter the bilirubin level rose sharply. Clinically the development of skin jaundice lagged behind the level and rise of the serum bilirubin. Their exchange transfusions markedly lowered the bilirubin levels. Despite certain limitations they report that their data shows a clear correlation between the development of kernicterus and the height of the serum bilirubin level. This correlation is shown in the following table.

SERUM BILIRUBIN LEVEL AND DEVELOPMENT OF KERNICTERUS

Serum Bilirubin	*Incidence of Kernicterus*
0 to 5 mgm per 100 ml	0
6 to 15 mgm per 100 ml	3 per cent
16 to 30 mgm per 100 ml	18 per cent
31 mgm and higher	50 per cent

In their last 100 cases Hsia, Allen, Diamond and Gellis have attempted to keep the bilirubin level below 20 mgm per 100 ml in each case by doing multiple exchange or replacement blood transfers if necessary. No cases of kernicterus have been encountered in this series.

Technique

If the umbilical vein is not available, then the saphenous vein in the middle of the upper thigh should be used. The plastic (polyethylene) catheter should be threaded carefully through the saphenous vein into the femoral vein and into the inferior vena cava through the external iliac vein. Sharp ends of the catheter should be eliminated to prevent traumatizing or puncture of any of the above veins.

In order to locate the saphena magna vein the following steps should be taken.

a. Draw a line between the anterior superior spine of the ileum and the public tubercle.

b. Bisect this line.

c. One to one and one-half cm. below this point, which is the center of the upper thigh region, a 1 to 2 cm transverse superficial incision is made medially and parallel to the inguinal ligament.

d. After carefully spreading the skin and superficial fat with a small hemostat, a layer of superficial fascia is seen through which the saphena magna vein is visible.

e. Split the fascia, isolate the vein, and tie the plastic catheter in after the end is in a sufficiently large pool of blood so that there is a good easy flow from the catheter.

Heparin should be given in 1 to 2 mgm per kilogram of body weight to prevent clotting in the system. Two cc of five per cent calcium gluconate should be given intravenously for every 100 cc of citrated blood used. Cortisone and ACTH may be used before and after cross transfers of blood in an attempt to control the formation of antibodies. Antibiotics should be given for the prevention of infection.

Blood transfers are not without danger, and should be given only on adequate indication. By far the greatest danger lies in the theoretical mismatching that can occur because of the human element required to match bloods. With the passage of time additional blood factors similar to the Rh Factor may be discovered. Homologenous serum jaundice may be transmitted from carriers and other virus infections may be discovered in the future to be capable of transmission. Salisbury[13] reports mystifying late reactions beginning 24 hours after the cross transfer of blood. The reaction consisted of fever 100 to 104° F.; usually not accompanied by malaise, headache, or anorexia.

Summary

1. The use of a new pan-(all purpose) transfusion system is presented for the first time.

2. A brief case report of the use of this system in a reciprocal blood transfer between a hemophilac child and his donor father is presented.

3. A case report of the use of this system in a replacement blood transfer of an anuric nephrotic child followed by a remission is presented.

4. Indications for blood transfers are given.

5. The technique for performing blood transfers is outlined in full.

6. The dangers following blood transfers are listed.

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WILMS' TUMOR OF INFANCY AND CHILDHOOD*

WILLIAM BENZING JR., M.D.

TULSA, OKLAHOMA

Infancy and childhood have been specified in the title of the paper as Wilms' tumors have been reported with some frequency in adults, whereas the present study is based upon eight cases observed in infants and children, the usual hosts for these malignancies. While Wilms' tumors are sometimes found in adults hypernephromas and other types of renal malignancies are practically never found in infancy and childhood, the Wilms' tumor constitutes the most common abdominal neoplasm in this age group.

According to Wilms these tumors arise from an undifferentiated mesodermal cell which in the normal course of development gives rises to striated muscle, bone and the nephrotome, the anlage of the kidney. Because of the multiple potentialities of the cell from which the tumor takes origin one is apt to find several types of tissue in a Wilms' tumor, such as connective tissue, epithelial tissue, cartilage, bone and muscle.

Pathology

Wilms' tumors are rapidly growing malignant tumors of renal origin, although a certain percentage of them seem to have an extra renal origin. They not only grow rapidly but silently and are not usually discovered until they produce symptoms by their mechanical presence hence they may reach a tremendous size before being discovered. Tumors weighing as much as 5000 grams and measuring up to 40 centimeters in diameter have been reported. As a rule these neoplasms are quite well encapsulated but the capsule is tightly adherent to the renal parenchyma and cannot be separated from it without tearing away some of the kidney substance. The surface of the tumor may be smooth or lobulated and its consistency, while usually soft, may be hard and fibrous. The tumor may arise from any portion of the kidney, and is occasionally extra renal, but is more common at the lower pole than elsewhere.

The cut surface of the tumor is glistening. In small tumors the color is a more or less uniform grayish-white or pink but in large specimens one encounters areas of discoloration due to hemorrhage and fatty or myxomatous degeneration, and, in some large tumors there may be a soft, gelatinous center. Perhaps 10 to 15 per cent of the neoplasms show an amorphous calcification.

In the eight cases of the present series none of the tumors were bilateral although the literature states that there is some tendency for bilateral occurrence.

Microscopically one finds that the apparently well encapsulated tumor may actually be invading the kidney substance. The predominate cell in most instances is a highly undifferentiated, hyperchromatic, r o u n d, oval, or spindle cell. The cells may be arranged in solid sheets or may assume a strand or cord-like arrangement. In some instances there may be a paucity of undifferentiated cells lying in the midst of a dense connective-tissue stroma. The quantity of stromal tissue varies from tumor to tumor and from section to section in the same tumor. In some sections the stromal tissue may be almost imperceptible while elsewhere the stroma may form the major part of the tissue. In only one instance in the series being reported upon was there any attempt at the formation of tubules or glomeruli and this was of a very abortive character. Muscle cells were identified in two of the cases but constituted an inconspicuous part of the tissue.

One usually encounters both epithelial and connective tissue structures in these tumors in varying proportions. Many of the tumors contain glandular tissue which may form well-defined tubules and glomeruli or may form very abortive and immature renal structures. There is also a strong tendency for rosette formation by the epithelial elements. Along with the immature epithe-

*Presented before the General Session at the Annual Meeting of the Oklahoma State Medical Association April 14, 1953.

lial elements one finds embryonal mesenchymal tissue from which the fat, fibrous tissue, cartilage, muscle and bone sometimes encountered in these neoplasms are derived. If muscle tissue is present it may be of the striated or smooth type. Ectodermal and endodermal structures such as skin, alimentary and respiratory tissues are never found.

There is a definite and strong tendency for these tumors to invade the veins and blood-borne metastases are most common in the lungs and liver. Once the tumor capsule is ruptured local spread occurs rapidly with the invasion of adjacent structures such as the kidney hilus, renal vein, inferior vena cava, peritoneum, duodenum, ureter, lymph nodes and aorta.

History and Physical Findings

The average age of the child with a Wilms' tumor will be about three years, although cases have been reported in the newborn and in adults. Perhaps 80 per cent of the cases occur before the age of eight. In the cases under discussion the youngest was 12 months and the oldest eight years. The sexes are affected about equally and the two sides of the abdomen are equally involved.

By far the most common symptom and physical finding is an abdominal mass that has shown progressive and painless enlargement. The mass is not tender and may fill an entire half of the abdomen and even extend across the mid-line. There seems to be a tendency for the Wilms' tumor to be limited to one side of the abdomen whereas the neuroblastoma tends to cross the mid-line. This little difference in behavior may serve as a point of differentiation between the two.

Because of the encapsulation of the tumor hematuria does not occur early. It is usually a late symptom and its presence carries a poor prognosis since it usually means that the tumor has broken through its capsule and is invading continguous structures. Oddly enough, one of the two cures covered by this report was in a child of seven whose chief, and only complaint, was hematuria, the mass not being discovered in the abdomen until she entered the hospital. So, although the prognosis may be poor in the presence of hematuria it is by no means hopeless.

Fever is a common finding and was present in six of the eight cases. It may be intermittent or of the continuous typhoidal type. Abdominal pain is not usually present. Loss of weight is not prominent when the child is first seen, the majority being fairly well nourished. Late in the disease the loss of weight and cachexia are marked.

Other symptoms and findings that may appear, due primarily to the mechanical presence of the mass or its metastases are anorexia, vomiting, constipation, pallor and enlarged, tortuous superficial veins over the abdomen and lower thorax. Hypertension has been reported by some investigators but none was observed in this series.

Urinary symptoms are conspicuous by their absence, although, as pointed out above, there may be hematuria.

Laboratory Findings

The laboratory is not of much assistance in helping to make a diagnosis of Wilms' tumor. There is usually a mild secondary anemia with the hemoglobin between 60 and 70 per cent and a red cell count of 3,000,000 to 4,000,000. There is a slight leukocytosis of 10,000 to 14,000 but normal white counts are not unusual. A urinalysis may show the presence of microscopic blood.

Roentgenography

Pyelography is essential in the identification of this lesion and when combined with the history and physical findings will make the diagnosis almost certain. As a rule, intravenous or intramuscular pyelograms give all the necessary information and retrograde studies, which are not too desirable in this age group, can be omitted. Retrograde studies were not necessary on any of the cases to be presented.

The preliminary flat plate of the abdomen will often demonstrate the tumor. There may be displacement of the intestinal loops to one side, or, in the case of very large tumors there may be elevation of the diaphragm on the affected side. There may be bulging of the flank and perhaps the tumor mass itself can be outlined. If calcification or bone is present the indentification is made easier. With the abdominal flat plate one should, of course, obtain a chest film to rule out metastasis.

The character of the urographic findings will depend upon the size, location, and metastatic spread of the tumor. Most of the tumor effects upon the pyelogram will be due to mechanical pressure on the pelvis, calyces and ureter rather than actual invasion of these structures, for, as has been noted, the neoplasm is usually well demarcated from the renal parenchyma. There may be no visualization of the kidney on the

affected side or the visualization may be normal. The pelvis and calyces may be distorted with or without displacement. If the ureters are visualized they may show lateral displacement on the normal side due to extension across the midline. Ureteral displacement on the affected side may be either medial or lateral, the former being the more common.

The displacement of the kidney may be upward, downward, lateral or medial depending upon the location of the mass, i.e whether it arises from the uper pole, lower pole or medial margin. The usual displacement is upward and medial. Neuroblastoma is more apt to displace the kidney laterally than is Wilms' tumor and in the literature this is mentioned as a point in the differential diagnosis.

The type and degree of distortion of the pelvis and calyces will of course depend upon the position and size of the tumor. A tumor arising from one of the poles may not impinge upon these structures and hence no compression changes will be noted. Only a single calyx adjacent to the growth may show flattening or distortion or the entire kidney collecting system may be flattened, elongated and distorted as it is stretched over the expanding tumor.

Sometimes the picture is that of hydronephrosis and one not acquainted with the clinical history might overlook the tumor as the cause. Neoplasms arising from the lower pole or medial margin of the kidney may involve the ureter or the ureteropelvic junction early with the production of hydronephrosis, or, they may produce a hydronephrosis indirectly by dragging the kidney downward with their weight.

Differential Diagnosis

There are a number of lesions that may be confused with a Wilms' tumor either on the urogram or on the physical examination. In the differential diagnosis one must consider suprarenal tumors, hydronephrosis, polycystic disease, splenomegaly, hepatomegaly, pancreatic cyst, retroperitoneal tumors such as lymphosarcoma, ovarian tumors, and psoas abscess.

Prognosis

The prognosis in Wilms' tumors is poor and death is apt to occur from 12 to 18 months after the patient's first admission. Various authors have placed the mortality at from 80 to 100 per cent but the outlook is actually not so black as a fairly extensive review of the literature places the mortality at approximately 60 to 80 per cent. Some statistics show a cure rate of 47 per cent and this is undoubtedly the peak cure rate possible.

Recurrences usually make their appearance in six to 18 months although recurrences have been recorded as late as four years post-operatively. This however is the exception rather than the rule and if the child survives two years without evidence of recurrence there is good probability of a cure.

The cell type of the tumor has no relation to its curability, nor does its size, as cures have been reported in tumors of tremendous dimensions. The age of the patient however seems to have a definite effect upon the outcome. In studying the reported cases it is clearly evident that the younger the child the better the prognosis. Gross and Neuhauser have some interesting figures on this score. Between 1940 and 1947 they had 80 per cent probable cures in patients under 12 months of age and only 43.3 per cent probable cures in patients over 12 months of age.

The prognosis must be guarded. Some apparently well encapsulated and readily removable tumors may spring up with a local recurrence or distant metastases months later. On the other hand cures have been reported in inoperable cases where surgery was confined to biopsy and was followed by roentgen therapy. There is one such case in the present series that will be presented in some detail. Even bilateral neoplasms do not offer an entirely hopeless prognosis. Gross and Neuhauser report a case of bilateral tumor that was treated with a nephrectomy on the right side and roentgen therapy on the left, the patient being alive and free of disease nine years later.

Treatment

The treatment may consist of surgery alone, roentgen therapy alone or a combination of surgery and roentgen therapy. There is a difference of opinion as to whether x-ray should precede surgery, follow surgery or be administered both before and after surgery but there is general agreement that neither surgery alone nor irradiation alone is sufficient and that the best plan of treatment is a combination of the two. It is my opinion that delaying the surgery for pre-operative irradiation jeopardizes the patient's chance for survival, since no one knows when metastasis will occur, and ma-

lignant cells might enter the blood stream even while the patient is being irradiated prior to surgery. Pre-operative irradiation will accomplish one important thing and that is it will markedly reduce the size of the tumor and hence greatly facilitate the removal of large bulky tumors that might otherwise be difficult to handle.

Post-operative irradiation is vital in all cases, operable and inoperable, because of the tremondous effect it exerts upon some of these malignancies. One of the two cures being reported in this series of cases received only x-ray as a therapeutic measure. McNeil and Chilko report a three year cure of a boy of 14 months who received only roentgen therapy. Dean treated 20 patients with x-ray only and obtained five cures. Dickey and Chandler report a survival of eight years in a case that was declared inoperable and was treated with x-ray only. Pohle and Ritchie report a cure in a 10 month old infant who was explored and declared inoperable and then given x-ray therapy. Sauer has a 10-year cure in a child who was declared inoperable at the age of two following an exploratory. Nesbitt and Adams have a 10-year survival in an inoperable case. Bixler, Stenstrom and Creevy report the case of a child who had the primary lesion treated by x-ray alone. Within a year the child had pulmonary metastases, one in the left apex and one in the right base. Both metastatic lesions disappeared with roentgen therapy and the patient was alive and well three years following the original treatment. This is an extremely unusual case as the metastases from these malignancies are much more radio-resistant than the primary lesion and do not respond nearly so well.

The above examples are not cited with the intent of advocating x-ray alone in the treatment of Wilms' tumors but merely to point out the potent effect that it sometimes exerts and to stress the importance of post-operative irradiaion.

Time and space do not permit a detailed report on all of the eight cases forming the basis of this paper but a review of the two cases that resulted in cures will point up the salient features of most cases of Wilms' tumors.

CASE *III*: C. S., a white male 13 months of age, was admitted to the hospital April 24, 1944, with a mass in the left abdomen. The hemoglobin was 70 per cent, the red cell count 3,500,000 and the white count 10,600. The urine was negative. Pyelograms showed a normal kidney and psoas shadow on the left, with prompt filling and no gross abnormalities. The left ureter was displaced laterally. On May 4, 1944, the left kidney was exposed and found to be normal. Anterior, medial and inferior to the kidney was a mass 6 cm. in diameter that could not be freed because of its close adherence to the aorta. The surface of the mass was white, interspersed with soft, depressed areas of hemorrhage. A biopsy was taken, the abdomen was closed and the pathologic report on the tissue was Wilms' tumor. The child received x-ray therapy to the left kidney region through anterior, posterior and lateral ports. The child was last seen in July of 1952 with no evidence of the disease and with a normally functioning kidney on the left as demonstrated by intravenous pyelography.

CASE *IV*: S. L., a white female seven years of age, was admitted June 27, 1944. Her only complaint was of hematuria for two days prior to admission. Physical examination revealed a smooth mass in the right side of the abdomen extending from under the costal margin down to the level of the umbilicus. The mass was thought to be liver. The temperature was 99.6 degrees centigrade. The hemoglobin was 70 per cent, the red cell count 3,860,000 and the white count 5,600. Roentgen studies revealed a mass in the right upper quadrant. The renal pelvis and calyces were displaced superiorly and medially, and were compressed, elongated and distorted. The right ureter was displaced medially over the spine. At operation, July 1, 1944, a tumor was found arising from the lower pole of the right kidney, measuring 13 x 11 x 9.5 cm. The mass and the kidney were removed and the pathologic diagnosis was Wilms' tumor. This child also received roentgen therapy over the right kidney region through anterior, posterior and lateral ports. This little patient was last seen on January 14, 1951. She was alive and healthy with no evidence of disease.

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MIDDLE LIFE AND MENTAL DISEASE*

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The writers, classical and popular, who have been so prolific in their productions about youth and its joys, have usually been singularly quiet about middle age and its invariable accompaniments. When they have considered it at all, their opinions as to its pleasures and its vicissitudes are at wide variance. At one end of the scale there is Carolyn Wells, who states that:

> "Youth is a silly vapid state
> Old age with fears and ill is rife
> This simple boon I beg of fate
> A thousand years of middle life."

At the other extreme is the writer who regards middle age as a curse and who states that the best thing than can be said about a middle aged person is that he has likely learned to have a little fun in spite of his troubles.

Whatever lay opinion might be regarding this phase of our existence, the practitioner of medicine knows that there is a bogey about middle age in the minds of many people, especially about what it portends, and this reaction brings with it a chain of symptoms. While it is true that much of the anxiety which causes these symptoms is due to lack of understanding, the fact remains that the symptoms which arise are just as distressing as if the situation were real.

The purpose of this presentation is: (1) to call attention to the impact of contemporary cultural and economic pressures upon people in the middle and older age group; (2) to examine the psychological and endocrinological factors at work in the female during the climacterium; (3) to note the

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fact that the male in his fifties frequently goes through a disturbing time psychologically; and (4) to indicate those patients who will do best under the treatment of their own personal physician.

It is a commonplace to note that present-day economic, cultural, and social pressures have a particularly marked effect upon people in middle and older age groups. This is actually nothing new, for people's reactions have always been influenced by the *zeitgeist*, or spirit of the times, and they have always been subject to the pressures and difficulties of their environment. The country doctor has always known that the familial and social pressures of the family and the community have been reflected in his patients' symptoms, but in the specialized practice of medicine we have frequently lost sight of this. In the latter part of the last century William James wrote:

> "A man's life is in its widest possible sense the sum total of all he can call his, not only his body and psychic powers, but his clothes, his house, his wife and children, his ancestors and friends, his reputation and his works, his lands, horses and yacht and bank account. All these things give him the same emotions."

Certainly the same thing may be said today in a culture where material success is regarded as the *summum bonum* and yet where its attainment does not bring with it the desired happiness, security or freedom from anxiety.

Nearly every physician has encountered female patients who, having raised a family and having attained some leisure and reasonably comfortable circumstances, have begun to show neurotic symptoms in the form of vague somatic complaints. Usually their children have married and left home; their husbands, having attained some position, are occupied with their work; and there is now no one left who is dependent upon them and in need of their ministrations. The longed for leisure period has arrived and it is found unpalatable. This phenomenon we have called the "need to be needed," and failure of its gratification may result in the production of numerous complaints and bizarre symptoms.

In normal woman one of the most potent causes of anxiety and mild depressive symptoms is her concept of herself as a human being. All of her life she was brought up to cherish ideas of her own self worth and to guard and appreciate her prerogatives. Now in middle life there is a threat to this idea which is both conscious and unconscious. In addition to what she interprets as fading usefulness in a culture in which service and efficiency are the watchwords, there is the loss of her reproductive power and a vague spectre of old age in the distance. Along with a lessening of responsibility, there is also a noticeable increase of fatigability, a loss of friends through death and varied circumstances, and perhaps a hint of economic stress arises as does the possibility of becoming dependent upon someone. All of these factors add up to insecurity and they are particularly distressing in the present culture. Insecurity, in turn, is the foundation upon which anxiety and depressive symptoms are prone to arise.

Understandably, some of the symptoms of anxiety of the female patient in middle life will become fixed upon the pelvic organs for they, due to a variety of causes, are frequently in the consciousness of women who are undergoing the menopause. The fact that pathological emotions are prone to appear during the time of the menopause has been recognized for a long time and commented upon by various writers. Bruce de Boismont described melancholia, which follows the menopause, in 1842. In 1878 Hegar stated that after the menopause the diseases of the nervous system came next in frequency to those of the sexual organs. Bonner in 1886 said that the personality changes are frequently the first sign of the menopause and indicate its approach. He also stressed the frequency of depressive reactions during this period of a woman's life. Braxton Hicks, in the Croonian lectures of 1877, remarked that after the change is completed the system improves. The many irritations connected with menstruation and pregnancy are gone and the changes in the individual show that many of the earlier troubles were functional without prominent lesion. A. F. Currier in his treatise, *The Menopause*, published in 1897, said: "I can never see the sense nor the logic of the traditional teaching, repeated generation after generation, that the menopause was a time and experience which matron and maid alike should approach with fear and awe."

Though there has been a difference of opinion through the years regarding the et-

iology of the emotional symptoms which occur during the menopause and some have insisted upon a psychological causation while others believed just as strongly that it was endocrinological, it is now generally believed that the psychiatric symptoms which appear at this stage of life are of a functional nature and that endocrinologic changes have but little to do with them. Greenhill stated in 1946: "There is no justification for the term menopausal syndrome if it includes a psychiatric disorder in its definition." He noted further that the metabolic instability inaugurated in response to failing ovarian function has its paramount effect upon the autonomic nervous system and is responsible for the common symptom of the "hot flash." He concluded that the majority of women experience no symptoms of a psychiatric nature during the menopause and that they handle without difficulty any mild symptoms of autonomic-over-reactivity.

Greenhill's statement is concurred in by most psychiatrists today and he notes, as do other clinicians, that pre-existing psychoneuroses may be exacerbated at the time of the climacteric and that estrogen therapy is of no value in these psychiatric symptoms.

Even though it might appear that neurotic symptoms have arisen *de novo* during the menopause, careful examination will reveal the presence of a previously existing neurosis. Also, it has been pointed out that psychiatric problems may arise during the involutional period which obviously cannot under any circumstances be connected with the menopause in any way. The evidence that involutional melancholia is a direct result of the climacterium is in no way conclusive and, in fact, modern psychiatry teaches that there is no cause and effect factor operative here except that the climacterium is a period of stress.

The most commonly observed emotional phenomena in menopausal women are depression and anxiety reactions. Their genesis is concerned intimately with the individual's capacity to adapt to changes taking place in her internal or external world. If she can do this, she can be said to be adjusting and is at peace with the environment. If the adaptive methods (which incidentally are learned mechanisms) fail, however, the individual is at odds with her world, her security is threatened and anxiety arises.

In the words of Selye, the force that breaks down these adaptive mechanisms is called "stress." Thus, to reiterate, stress acting upon the individual's adaptive mechanism threatens her basic security and calls forth anxiety. When she becomes anxious, she mobilizes all of her resources as defenses. If these defenses are inadequate, she continues in a state of anxiety.

It can readily be agreed that the climacterium is potentially a period of stress and we have already noted the stressful biosocial changes and, also the fact that this period of a woman's life is colloquially known as the "change." Referred to by some as a catabolic phase, it is certainly marked by a dynamic changing set of metabolic events. If the woman has good adaptive mechanisms to this form of stress, then she will not present the symptoms of anxiety or depression; if she does not, she will. The climacteric, however, is not the only form of stress capable of producing symptoms which can befall a woman during this stage of life. Many other things can happen to her in her environment and her emotional reactions to all of her difficulties might be the same. Hence, there are no specific mental symptoms which directly characterize the climacteric.

To elaborate another point, since defenses against anxiety are learned early in the emotional development of an individual and are used repeatedly in subsequent periods of stress, it is easy to see how these defenses are brought into play once more during the stress of the menopause. If a woman has successfully handled the anxieties of her emotional development in the past, the chances are that she will do so again during the period of her menopause. The pre-menopausal personality or the previous state of mental adjustment, therefore, is an important factor in determining whether or not the woman will have an emotional upheaval during her change of life. We have already stated that the woman who is "neurotic" before her climacteric is the woman who is predisposed to an emotional reaction of some sort during her climacterium.

At this point it might be well to emphasize the quantitative and qualitative relationships of these etiological factors, important in the genesis of emotional reactions seen during the menopause. There are various kinds of women (personalities), with various kinds of adaptive mechanisms and with

various kinds of environmental influences (internal and external) causing various kinds of stress, which in turn call forth varied emotional responses. Variability, then, typifies the situation.

Basically, a person's psychological well-being is dependent upon his capacity to adapt to situations, to be able to relate to individuals, and to be able to give or receive attention and affection. An individual's basic happiness is dependent upon the ability to give of herself for others, whether they be family or friends, and this giving must be done without bitterness, regret or resentment.

What are the things which potentially threaten the woman at the time of her menopause and what is she in danger of losing? This falls into two categories: (a) those things relating to herself that she must relinquish; and (b) those things in the environment which she may have to lose. In general when we have to give up things which are part of ourselves, anxiety is aroused—this is understandable, for our basic instinct of self-preservation has been mobilized and our bodies are kept in a state of physical readiness or tension or anxiety. The female at the time of the menopause is in a position of having to relinquish a part of her feminine prerogatives, her child-bearing proclivities. If she is basically a secure person, she will have little difficulty; if she is not, she will.

Regarding the loss of anything in our environment, we react to this by feeling depressed. This is also understandable—what has been loved has been lost. What are the things in the environment which menopausal women are required to give up? One, as already mentioned, is the weaning away of her children; others are the loss of her position, her friends, her changing circumstances, etc. Many of us have seen women whose depression was precipitated by a move from a home which the family had occupied for a number of years. This loss or deprivation of objects, particularly if there were mixed feelings about them, is productive of depressive feelings.

The woman who, at the climacterium is under the necessity of relinquishing some of her basic gratifications can find gratifications elsewhere than in herself. Thus, one of the most therapeutic and prophylactic things a woman can do is to find substitute things which will compensate her emotionally. Failure to do this exposes the individual to the possibilities of depression.

Due to limitations of time, the endocrinological aspects of this problem cannot be discussed here. If there is any doubt regarding the importance of the influences of the emotional states upon body metabolism, confirmation of this importance can be found in the work of many investigators outside of the field of psychiatry. In this regard, the conclusions of the anatomist and endocrinologist, G. W. Harris, are of great significance. He states:

> "One of the striking facts emerging from recent work is the emphasis on emotional and psychological factors in the control of endocrine secretion. The relationship between emotional stimuli and the secretion of the adrenal medulla has long been known, but it is now apparent that the secretion of the antidiuretic gonadotropic and adrenocorticotrophic hormones from the pituitary gland may be influenced by emotional states."

Not enough attention is paid to the fact that the male undergoes a series of changes, usually in his fifties, which are troublesome. While these changes are not as dramatic as those which occur in the female, they are worthy of our attention, for they may evidence themselves in physical or psychological symptoms and be presented to the physician as a diagnostic problem.

The physical manifestations which occur are often nebulous and not infrequently are accompanied by signs of sympathetic nervous system disorder. The emotional symptoms are usually those of anxiety and depression, often accompanied by dissatisfaction with one's family, work or accomplishments. Some have dignified these symptoms with the appelation, "male menopause," and, though this term is obviously a misnomer, the condition which it designates is real enough.

One sees these symptoms in men who have been rather successful and in some it seems to appear because there are no more worlds to conquer. William James, in his *Death and the Value of Life*, states that the sovereign cause of melancholy is repletion. Nietzsche, speaking of the same thing, calls it the "melancholy of everything completed." Actually, what these symptoms portend

is the advent of psychological and physiological adaptation which this stage of life calls for and which is taking place imperceptibly. The condition lasts over a period of several years and, while recovery is usually spontaneous, the individual needs wise counsel and the advice of his physician. Though glandular changes are certainly taking place at this period of a man's life, as they are at all others, it is agreed generally that these psychological symptoms are not due to glandular deficiency and replacement therapy is not indicated.

When these symptoms in the male are very mild, there is little difficulty and the individual can continue with his work. When the symptoms are severe and there is evidence of an agitated depression, the situation being obvious can also be handled readily by one's psychiatric colleagues. It is when the symptoms are nebulous and nonspecific and when there do not seem to be enough disturbing elements in the surrounding environment to account for them, that the problem of differential diagnosis arises.

This is an unhappy group of men. They blame their discontent upon the surroundings, whereas it resides within themselves. They are complaining and difficult to get on with in their homes and in their work. Because of irritability and emotional outbursts, these men at times alienate their children, friends and business associates. In professional men, the situation can become seriously complicated.

The type of individual prone to difficulty in the fifth decade is the dynamic, successful, somewhat obsessive, rigid, driving type of person. This is the same type of personality make-up which is the forerunner of involutional depression in those whose illness is fated to become more severe. The encouraging thing about these people is the tendency for recovery under supportive therapy. They need advice and guidance and a chance to talk over their problems. In many of them there is already a semblance of insight and they desire assistance if it does not have to be purchased at too great a price to their self-respect. Again, in these instances, glandular medication is not indicated.

The question now arises as to how we can help the men and women who are passing through these crises of adaptation. First, of course, they all are entitled to a thorough examination so that the physician who is to guide them through the illness will be aware of their potentialities and any threats to their basic security. Secondly, the physical manifestations must be treated symptomatically. Replacement therapy with estrogen should be used judiciously and chiefly to alleviate vasomotor symptoms.

Thirdly, one must survey the life situation of the individual in question for the cause of the difficulty is usually to be found in the type of personality involved and a series of precipitating events in the environment.

There is one statement in the recent literature which would interest us here. Doctor Clause, a gynecologist, speaking at a Cornell conference said:

> "I believe strongly that the menopause should be treated by the doctor who knows the patient best, not necessarily the one who knows the disease best. The person's emotional state and personal problems are much harder to handle than purely medical problems. The doctor who knows the patient well and who has inspired the patient with confidence in him is the one to treat her. Beyond that, it is a matter of indifference whether he is a general practitioner, surgeon, or anything else."

It is obvious that there is much wisdom in this statement.

For the management of the mild anxiety and depressive reactions many women can be relieved of these symptoms by establishing a warm, friendly relationship with a physician who listens to her story with sympathetic, benevolent attention; who is objective, not passing moral judgments; who has a comprehending friendship with her; who speaks to her in common-sense terms about the present and the future; and who takes plenty of time to do all this ungrudgingly. These women are under stress and they often need such support. If the emotional problems are of greater magnitude and the symptoms of anxiety and depression are severe, then the physician should enlist the aid of his colleague, the psychiatrist, who is trained to cope with the more intense emotional reactions.

I am not, therefore, going to go into the details of the involutional psychotic reactions with you. They belong in the hands of psychiatrists and in institutions, for they

are potentially suicidal. The new psychiatric nomenclature describes these reactions as follows:

> ". . . psychotic reactions characterized most commonly by depression occuring in the involutional period without previous history of manic depressive reaction and usually in individuals of the compulsive personality type. The reaction tends to have a prolonged course and be manifested by worry, intractable insomnia, guilt anxiety, agitation, delusional ideas and somatic concerns. Some cases are characterized chiefly by depression and others chiefly by paranoid ideas. Often there are somatic preoccupations to a delusional degree."

It is in the agitated depressions that electric shock therapy is of the greatest usefulness.

More than any group of patients menopausal women tend to make demands upon a physician's time and to require much reassurance and personal encouragement. Often the appreciation of these women is a source of professional gratification to the physician who has patiently and skillfully led them, supported them, and educated them through this trying period.

To summarize briefly the main tenets of this discussion:

(1) All illnesses, particulary the psychologic and pscho-somatic, are influenced by the milieu in which they occur and are colored by the social and cultural pressures upon the ill person.

(2) The menopause signifies the cessation of ovarian activity and function. Physiologically it means the end of woman's active reproductive life. Psychologically it means that she has to reorganize her feelings about her own sexuality.

(3) The majority of women are able to adapt to or make adjustments to the changes of the climacteric without severe emotional upheavals.

(4) Of those emotional reactions seen in women during the menopause anxiety and depression are the most common. These reactions are not specifically characteristic of the climacteric but can be if the climacteric represents severe stress to the woman and she does not have sufficient adaptive mechanisms to handle it.

(5) The patient's ability to handle stress during this period of her life is dependent upon her basic personality make-up, which is predetermined before she enters the period of her menopause.

(6) The problem of the menopausal woman is a real psycho-somatic one. The physical and emotional aspects of it are so intimately intertwined as to make them practically inseparable.

(7) It must be remembered that the male of the species is vulnerable to emotional distress in its various manifestations, particularly during the involutional period.

(8) The physician who knows the patient best is the therapist of choice.

HAVE YOU HEARD?

A. M. Evans, M.D., Perry, has been named president of the staff of Perry Memorial Hospital.

Fred Dinkler, M.D. has opened his practice in Hennessey.

E. R. Flock, M.D., formerly of Muskogee, has moved his practice to Stigler.

George Merkley, M.D., recent University of Oklahoma graduate, has opened his practice in Boise City.

T. A. Trow, M.D., formerly of Henryetta, ha recently moved to Holdenville.

E. M. Childers, M.D., formerly of Tulsa, has moved to Sand Springs and has taken over the practice of the late J. S. Chalmers, M.D.

Virgle Wallace, M.D., has opened an office in Lawton. He is formerly of Gainesville, Texas.

William LeBlanc, M.D., Ochelata, has retired after 48 years of medical practice.

George H. Niemann, M.D., practicing physician in Ponca City for 49 years, has recently retired.

BLUE CROSS-BLUE SHIELD DRIVE IS SUCCESS IN OKLAHOMA COUNTY

A total of 10,369 new members were gained with 55 new groups during the intensive Blue Cross-Blue Shield open enrollment in Oklahoma county.

The biggest enrollment ever attempted by the plans, it was preceded by several promotion plans including the Mayor's proclamation, newspaper, radio and TV publicity, and enrollment booths in various locations. Individual physicians distributed more than 25,000 announcement stuffers to their patients. As a direct result of the activities of this special enrollment, it is believed that group enrollment will be stimulated for several months.

CHOICE OF OPERATION IN CARCINOMA OF RECTUM AND RECTOSIGMOID*

W. A. FANSLER, M.D.
MINNEAPOLIS, MINN.

In determining the operative procedure which is most suited to the individual patient there are three fundamental considerations:

1. The operative risk involved should be within an acceptable mortality rate;

2. The operation should be the procedure which, considering item one, offers the best chance of permanent cure;

3. Considering both items one and two the operation should be the one which will allow the patient to lead the most normal post-operative life.

It it were only a matter of permanent cure an abdomino-perineal resection with permanent colostomy is the procedure which is most radical and therefore offers the greatest chance of permanent cure. Unfortunately for this rule of thumb patients wish to avoid a colostomy and since in some cases abdomino-perineal resection is an unnecessarily radical procedure other forms of operation may be considered.

Actually, a colostomy properly cared for is but little handicap and of little inconvenience although it can scarcely be considered a desirable adjunct to social activities. If the situation is thoroughly explained I believe most patients will willingly accept a colostomy as a small price to pay for the permanent cure of a cancer. The only case in which a colostomy may be a difficult problem is in the physically or mentally handicapped. In such instances it may present a real problem for the patient and his attendants. Partly because of the patient's resistance and partly because of the surgeon's desire to avoid colostomy where possible, various operations have been devised to eliminate this feature of cancer surgery. After preliminary enthusiastic support these have become greatly restricted in their scope or entirely abandoned after short periods of popularity. Time has invariably shown the operations to be inadequate as evidenced by frequent local recurrence of the concer.

During the past few years as a result of careful studies as to spread of cancer of the rectum and rectosigmoid and the reduction of mortality rates due to better patient preparation and anesthesia, the question of "saving the sphincter" has again been given new impetus. We are greatly indebted to Dukes, Collen, Waugh, Gilchrist and David for studies of cancer spread. As a result of these and other investigations it is now possible to more accurately determine the probability of spread or rectal cancers. Because of this knowledge certain patients may be spared a colostomy without appreciably increasing the risk of recurrence of their tumor. It should be emphasized, however, that this is true only in carefully selected cases and that the surgeon and not the patient must be the one to decide whether or not a colostomy is necessary. All patients wish to avoid a colostomy and if the surgeon allows himself to be governed by the importunities of the patient or his family he is certain to do many "sphincter saving" operations which will result in local recurrences. Better allow the patient to go to a more acquiescent surgeon for his operation than to be persuaded to perform an ill advised "sphincter saving" operation.

Dukes and others have carefully studied the gross and microscopic spread of the tumor in relation to the rectum and the ad-

*Presented before the Section on Proctology at the Annual Meeting of the Oklahoma State Medical Association May 20, 1952.

jacent glands. Broders has given added information by his cystological studies. Combining these two methods of study it is possible to select with some accuracy the patients who should have a colostomy and those who may be spared this inconvenience.

In determining the probability and direction of spread of rectal cancer the rectum should be divided into three zones. These zones have usually been set by arbitrary measurements from the anus. Because of difference in the length of rectums, variation in the point of levator insertion and the location of the dentate line this seems to me to be a rather poor method of division. Rather than employing arbitrary measurements it is better to consider zone one as including the anal canal and that portion of the rectum involving the internal hemorrhoidal area through the insertions of the levator muscles; zone two as that part of the rectum above zone one and extending to the second valve of Houston and zone three that portion of the rectum and rectosigmoid above the second valve of Houston. The upper termination of zone one—the levator insertion—can be easily determined by internal palpation with the tip of the index finger. The upper margin of zone two as demarcated by the middle valve of Houston is easily visualized with the proctoscope. By this method, regardless of the variation in size of the rectum, the three anatomical divisions may be accurately determined for the individual patient. The spread of the tumor from zone one is to the inguinal glands, laterally and upward. In zone two the spread is laterally along the levators or levator fascia and upward. In zone three the spread is upward. Lateral or downward spread from zone three is possible only as a retrograde extension which may occur if the lymphatics or veins are blocked above. There is no definite knowledge as to how often this occurs. Ten per cent has been suggested as a possible figure. As an all over percentage this may be satisfactory although it would seem that this figure is probably too high in the case of small tumors and too low in the case of large lesions. Therefore, the size of the lesion and amount of invasion of the bowel wall should also be considered. The growth should be considered grossly from the point of size and pedunculation and attachment to the bowel wall as outlined in Dukes Classification. Cytologically the tumor should be evaluated according to Broders Classification or determined by microscopic study following biopsy. Combining these findings the surgeon should be able to arrive at a preliminary decision between a "sphincter saving" operation and abdomino-perineal excision. It is my opinion that a cancer in either zone one or two which has invaded deeper than the mucosal layer should be subjected to abdomino-perineal excision. A tumor which has invaded or is fixed to the muscle layer has potentialities of lateral spread too serious to permit anything less than an abdomino-perineal resection.

If a "sphincter saving" operation is thought feasible, resection with primary anastomosis or a so-called "pull thru" procedure may be employed. So far as I am concerned, I see little reason for "pull thru" technique. If this type of operation is sufficiently radical, bowel control must rest on the external sphincter muscle. This muscle is a rather weak voluntary muscle incapable of prolonged periods of contraction and for these reasons cannot adequately control the bowel movements. It is my belief that a more radical removal with less functional impairment may be achieved by resection and primary anastomosis. It is questionable whether there should ever be a "sphincter saving" operation done for cancers in zone one. In this location it is impossible to do sufficiently radical removal without sacrificing all the sphincteric mechanism. A properly constructed midline colostomy properly cared for is much more cleanly and desirable than a sphincterless bowel outlet in the perineum.

This briefly outlines the problems involved in selection of operation but the final decision should not be made until the operation is actually under way and the abdomen explored. It is only then that the surgeon can be sure of the presence or absence of gross local or distal metastases. Inaccessible or minute undeductible metastases can always be present but these are a hazard which both the surgeon and patient must accept. The surgeon's decision must be based on nodes or nodules he can see or feel. Even large

nodes may not indicate metastatic spread so it is our custom to remove enlarged glands or nodes and have a frozen section made during the progress of the operation.

With a clean abdomen and pelvis and a growth not penetrating the bowel wall and located in either zone two or three it may seem to be desirable to do a segmental resection with primary anastomosis. If so, the inferior mesenteric artery should be ligated near its juncture with the aorta. It is the custom of some surgeons to take down the splenic flexure of the colon and divide the bowel somewhere in the transverse colon. I cannot believe there is any material advantage in this maneuver as a routine measure. The distal point of division of the bowel should be at least six centimeters below the level of the tumor. It is important in determining the lower point of division to be sure that measurements are made with the bowel relaxed and not while being put on a stretch by upward traction. The bowel is very elastic and if division is made with the bowel on stretch it may be found later, when the bowel contracts, that the lower margin of the tumor is very close to the point of bowel division. Wide lateral, caudad and cephalad removal of tissues surrounding and adjacent to the bowel should be a matter of routine. Whatever type of operation is done merely "skinning out" the bowel is to invite a much larger number of recurrences.

So far, operative procedures have been discussed with the idea of permanent cure. In a good many instances it is evident that the best the surgeon can hope for is palliation. In this situation a "sphincter saving" operation is often advisable where it would not be considered if radical cure was the objective. One is willing to accept a somewhat greater chance of local recurrence if the patient can be spared the inconvenience of a colostomy during the remaining months or, occasionally, years of life. If there is extensive local involvement or local metastases, one stage abdomino-perineal resection or the Hartmann operation is still the operation of choice. In these cases fairly rapid local recurrence of the tumor is quite certain and in such cases it is better to establish a colostomy at once rather than being compelled to do a second operation later when obstructive symptoms occur. If, however, only distant metastases are present, resection with primary anastomosis is by all odds the best procedure. There is no slide rule method of determining the type of operation for each patient and there must be some flexibility in what is advised.

This discussion outlines a general pattern, which, with individual variation, permits the proper selection of operation for carcinoma in this location. I believe that only in "cut and dried" cases should the surgeon preoperatively commit himself as to what operative procedure he will employ. The surgeon is seldom justified in definitely promising the patient a "sphincter saving" operation other than in the earliest of lesions. It is usually to the best interests of the patient if the final decision is deferred until the abdomen is opened and explored. Cancers in zones one or two, except very small tumors which have not invaded the muscularis are best removed by abdomino-perineal resection with permanent colostomy. Not too extensive cancers in zone three without adjacent or distant spread may be frequently cured by segmental resection and primary anastomosis. If there is any question in the mind of the surgeon as to the best procedure he should err on the side of abdomino-perineal resection.

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President's Page

The recent session of the Oklahoma Legislature produced two highly publicized investigations of interest to the public and the profession. These were the investigations concerning narcotic, barbiturate and amphetamine violations and the problems of mental health care.

The end result of the narcotic investigation was the creation of an enforcement agency in the Attorney General's office to enforce the present law. The result of the mental health investigation was the creation of a new commission, a change in commitment laws and the addition of a little more than $2,000,000.00 appropriation for the financing of mental health care.

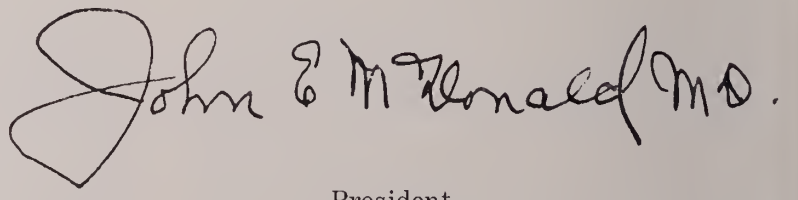
During the legislative consideration of the mental health appropriation and the mental health laws, the **Oklahoma City Times** ran a series of articles entitled, "Oklahoma Snake Pit—1953." The concluding chapter of this series highly complimented the committee of the Association appointed to inspect the Central State Hospital for their report. On the other hand, the article took the profession somewhat to task for its lack of initiative in not giving greater leadership in the inspection and operation of public health facilities to determine whether the public is getting its money's worth.

It is difficult to believe that the public at large or the Legislature individually would appreciate the Association interjecting itself into such matters any more than should the Oklahoma Press Association attempt to regulate and supervise the public press, the Oklahoma Bar Association, the state and federal courts, or the Oklahoma Farm Bureau the price of farm commodities.

Notwithstanding, the difference of opinion as to the extent to which organizations such as ours should police public institutions, we cannot forsake our responsibility to act in an honest scientific manner in the utilization of such facilities and the assistance that we can give them.

Medical education and individual physicians must keep abreast of the growing field of geriatrics. Physicians must counsel with families concerning the best care than can be given the aged who are not mentally ill. Physicians on sanity boards must be scientifically and medically honest in the determination of the need for the hospitalization of persons in our mental hospitals. Unless medicine accepts and discharges these responsibilities to the best of its ability, poor, if any, actual therapeutic medical care can be given to mental patients in the mental hospitals.

Under the new mental health law physicians hold the key to the doors of admissions to our state mental hospitals and we must accept our responsibility.



President



1. *Dizziness . . . movement is within the head.*
2. *Objective vertigo . . . the environment is in motion.*
3. *Subjective vertigo . . . the patient himself moves in space.*



2



3

TYPES OF VERTIGO:

Their symptomatic relief with Dramamine®

The disagreeable sensations of dizziness which physicians are frequently required to explain to patients have been described by Simonton[1] as varying from a slight sensation of confusion to severe vertigo.

While dizziness or giddiness is classified as a sensation of unsteadiness with a feeling of movement within the head, in vertigo the environment seems to spin (objective vertigo) or the body to revolve in space (subjective vertigo). Labyrinthine disturbances are likely to cause a sensation of rotation. Among the more common causes of dizziness or vertigo, this author lists: Damage to the vestibular nuclei or tracts in the central nervous system, involvement of the vestibular end organs by disease of the ear, Ménière's disease, toxicity of drugs, ocular vertigo from sudden diplopia, visual field defects, looking down from heights and motion sickness due to hyperactive labyrinthine reaction from riding in vehicles.

Dramamine (brand of dimenhydrinate) has proved effective in treating many of these disturbances. The indications for which Dramamine is now Council accepted include: Motion sickness, the nausea and vomiting associated with pregnancy, certain drugs, electroshock therapy and narcotization; vestibular dysfunction associated with streptomycin therapy; the vertigo of Ménière's syndrome, hypertensive disease and that following fenestration procedures, labyrinthitis and radiation sickness.

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SEARLE *Research in the Service of Medicine*

OFFICIAL PROCEEDINGS OF THE HOUSE OF DELEGATES

OF THE

OKLAHOMA STATE MEDICAL ASSOCIATION

APRIL 12, 1953

OPENING SESSION

The 60th Session of the House of Delegates of the Oklahoma State Medical Association was called to order at 1:00 P.M., April 12, 1953, in the Emerald Room of the Mayo Hotel, by the Speaker of the House, Clinton Gallaher, M.D., Shawnee.

M. B. Glismann, M.D., Oklahoma City, gave the Invocation.

Following the Call to Order, the Speaker introduced guests, including Mr. Tom Moore and Mr. Larry McHenry, Delegates from the Oklahoma Chapter of the Student American Medical Association, Mrs. Charles Smith, Norman, Oklahoma, President of the Woman's Auxiliary to the Oklahoma State Medical Association, and Mrs. Ralph B. Eusden of Long Beach, California, President of the Women's Auxiliary to the American Medical Association.

Mrs. Eusden gave a brief report of the aims, purposes and accomplishments of the Women's Auxiliary to the A. M. A., and its affiliation with the State Auxiliaries.

Following this, the Credentials Committee reported a quorum present.

The Speaker asked the pleasure of the House with regard to the minutes of the last meeting. E. H. Shuller, M.D., McAlester, moved: "That the reading of the minutes of the last meeting be dispensed with inasmuch as they had been published." Motion seconded and carried.

The Speaker announced that the next order of business was nominations for election of officers. He read the counties and councilors from Councilor Districts # 1, 4, 7, 10 and 13, which Districts' Councilors' terms were expiring and allowed a 10 minutes recess for these districts to caucus and decide on their nominations.

The House reconvened and the Speaker entertained nominations for President-Elect. John Burton, M.D., Oklahoma City, nominated Bruce Hinson, M.D., Enid.

The Speaker called for nominations for Delegate to the A. M. A. Malcom Phelps, M.D., nominated John Burton, M.D., Oklahoma City.

The Speaker asked for nominations for Alternate Delegate to the A. M. A. R. Q. Goodwin, M.D., Oklahoma City, nominated Doctor Malcom Phelps to succeed himself.

Doctor Gallaher asked for nominations for Vice-President. R. Q. Goodwin, M.D., Oklahoma City, nominated Ralph Smith, M.D., Oklahoma City.

The Speaker called for nominations for Secretary-Treasurer-Editor. T. H. McCurley, M.D., McAlester, nominated L. J. Moorman, M.D., Oklahoma City.

Doctor Gallaher next announced that the nomination of Bruce Hinson, M.D., for President-Elect without opposition, had made it necessary to replace him as Councilor from District No. 3, and asked District No. 3 to Caucus and present nomination for this office.

The Chair entertained nominations for Councilors and Vice-Councilors from Districts No. 1, 4, 7, 10, 13 and 3, which were as follows:

District No. 1, W. A. Howard, M.D., Chelsea, nominated F. S. Etter, M.D., Bartlesville, as Councilor and J. E. Highland, M.D., Miami, Vice-Councilor.

District No. 4, M. H. Newman, M.D., Shattuck, nominated L. R. Kirby, M.D., as Councilor and Joe Duer, M.D., Woodward, as Vice-Councilor.

District No. 7, T. A. Ragan, M.D., Norman, nominated Paul Gallaher, M.D., Shawnee, as Councilor and Charles Smith, M.D., Norman as Vice-Councilor.

District No. 10, L. D. Kuyrkendall, M.D., McAlester, nominated E. H. Shuller, M.D., as Councilor and Paul Kernek, M.D., Holdenville, Vice-Councilor.

District No. 13, Charles Ohl, M.D., Chickasha, nominated H. M. McClure, M.D., as Councilor and J. B. Miles, M.D., Vice-Councilor.

District No. 3, F. C. Lattimore, M.D., Kingfisher, nominated C. M. Hodgson, M.D., Councilor and Wm. P. Neilson, M.D., Enid, Vice-Councilor.

The next order of business was appointment of the reference Committees. Doctor Gallaher appointed the the following:

Committee on Resolutions

(To meet in Room 616, between session, or at the pleasure of the Chairman)

H. M. McClure, M.D., Chickasha, Chairman
J. D. Shipp, M.D., Tulsa
Ralph Smith, M.D., Oklahoma City

Sergeants-at-Arms

H. V. Schaff, M.D., Holdenville
L. C. Kuyrkendall, M.D., McAlester
Joe L. Duer, M.D., Woodward

Constitution and By-Laws Committee

Wm. N. (Bill) Weaver, M.D., Muskogee
Louis Ritzhaupt, M.D., Guthrie

The next order of business had to do with the time, place and date of the next Annual Meeting. The Chair recognized Walter H. Derseh, M.D., President of the Oklahoma County Medical Society, who read a letter from the Oklahoma County Medical Society extending an invitation to the Association to hold their Annual Meeting in Oklahoma City, in 1954. This invitation was accepted and the dates of the meeting announced as May 9-10-11-12.

The Chair announced that next on the agenda was the Report of the Officers. He called on James Stevenson, M.D., Tulsa, Delegate to the A.M.A., who was not present. John Burton, M.D., Oklahoma City, Delegate to the A. M. A., made the report. Doctor Burton

advised that there were two items that he believed of importance to report. First was the recent called session of the A. M. A., House of Delegates in Washington. He advised that this session had been called at the request of the President of the United States, and had to do with the formation of a Department of the Cabinet under the Federal Security Administration, this new Department to include Social Security, Medicine and Education, and would include a doctor of medicine in its make up. The second item to be reported was a breakfast representatives of the Oklahoma State Medical Association had with the Oklahoma Delegation of Congressmen in Washington. Doctor Burton advised that he believed this had been very beneficial both to the profession in Oklahoma and to the Congressmen who had advised they would look to the profession for advice and guidance on matters pertaining to medicine.

The Speaker announced that it was now the privilege of the Councilors to present a report from their Councilor District if they wished to do so.

F. S. Etter, M.D., Bartlesville, Councilor from District No. 1, announced there was no report from his district.

E. C. Mohler, M. D., Ponca City, Vice Councilor from District No. 2, reported briefly from District No. 2.

Bruce Hinson, M.D., Cherokee, Vice-Councilor from District No. 3, made a short report for that District.

L. R. Kirby, M.D., Cherokee, made a short report for District No. 4.

A. L. Johnson, M.D., El Reno, Councilor from District No. 5, reported briefly on District No. 5.

R. Q. Goodwin, M.D., Councilor from Oklahoma County, advised he had no report for District No. 6.

Paul Gallaher, M.D., Shawnee, Vice-Councilor, made a brief report for District No. 7, in the absence of the Councilor.

Wilkie Hoover, M.D., Tulsa, Councilor from Tulsa County, had no report from District No. 8.

F. R. First, Jr., M.D., Checotah, Councilor from District No. 9, made a brief report from District No. 9.

E. H. Shuller, M.D., McAlester, Councilor for District No. 10, reported briefly for his district.

A. T. Baker, M.D., Durant, Councilor from District No. 11, made the Report for his District.

J. H. Veazey, M.D., Ardmore, Councilor from District No. 12, reported for his Councilor District.

As neither the Councilor nor Vice-Councilor from District No. 13 was present, no report was forthcoming for that District.

L. G. Livingston, M.D., Cordell, Councilor from District No. 14, made a short report for District No. 14.

Following these reports the Speaker called for a Report from the Council. Alfred R. Sugg, M.D., Ada, asked Dick Graham, Executive Secretary of the Association, to make the report for him.

COUNCIL REPORT

Over the years the responsibility of interpreting the policies of the Association as determined by the House of Delegates and acting on its own initiative in lieu of directive of the House of Delegates, has given the Council a true realization of its responsibility to the profession and the public.

The Council is fully aware that physicians are human beings, and are subject to the same economic, political and professional reactions as any other group.

With the changing of the Federal Government leadership, there has tended to be a spirit of complacency and well being inculcated into many Americans. While your Council feels that the health and welfare of the public will be given conservative and sound consideration by the present Congress and Executive Branch of the Government, it nevertheless feels it is duty bound to point out to the profession that the next four years must be years of progress in health care for the people and it is the profession's responsibility to give the leadership to these programs.

In the absence of harrassment from Government, medicine and its allied groups are now, in many respects, charged with a greater responsibility than previously.

Although these comments of the Council are intended to represent progressive thinking, we must not lose sight of the fact that we are engaged in a war wherein American lives are being sacrificed and our youth being wounded and disabled. While we must give every consideration to civilian home care of the people, we must not lose sight of our responsibility to continue to render the finest medical care to our Military forces.

To accomplish the above will tax the ingenuity, ability and physical resourcefulness of our Profession.

In order that the Council Report may not be too long, the delegates are requested to pay close attention to the Committee Reports which will attempt to present a format to accomplish these observations.

MEMBERSHIP

The paid membership of the Association as of April 10, 1953, was 1,292 members, which is considerably larger than the paid membership on the same date last year but is less than the membership of 1,350 used as a basis for estimation of the budget by the Budget-Sub-Committee. On the basis of the total membership as of December 31, 1952, The Council can advise that the estimate of the Budget Sub-Committee in preparation of the budget, is an estimate that will be fulfilled. At the present time, the membership rolls of the Association contain the names of 105 Life Members and 48 Honorary Members while another portion of the Council Report will recommend the approval of one Honorary Membership and nine Life Memberships which will bring the Life and Honorary Membership Rolls to a total of 163. It should be noted from this analysis of the Life and Honorary Membership rolls that the number of Life and Honorary members remains relatively constant from year to year, which the Council believes should be sufficient to allay any fears that the granting of Life and Honorary memberships has any appreciable effect upon the revenue of the Association.

FINANCE

The financial structure of the Association remains sound. The Council has reviewed the recommendations to be made by the Organization Committee with regard to the management of the office and its financing, and recommends its approval.

ORGANIZATION COMMITTEE REPORT

Your Council would point out in the report of this Committee that there are some surplus funds of the Association and that the Committee presents several plans for the investment of these funds including the establishment of a building fund for permanent headquarters. Your Council recommends to the House of Delegates that they give serious consideration to the establishment of a building fund from a surplus fund of the Association in this fund.

Your Council further feels that a Retirement Program for employees is sound business procedure and commends the Committee for its work and recommendations in this field.

PUBLIC POLICY COMMITTEE

Your Council has been privileged to review the report of the Public Policy Committee and recommends its adoption.

Your Council feels, however, that it should comment with regard to the report of the Public Policy Committee as it pertains to the activities of the Oklahoma Legislature and its investigating committees on Narcotics and the Central State Hospital.

The Public Policy Committee will submit to this House of Delegates Resolutions covering the activities of these two committees and your Council requests that the House of Delegates give careful consideration to their adoption.

With regard to the expose' and the record that has been made before the narcotic investigating committee, your Council takes the firm position that as soon as the record has been completed that it is the obligatory duty of the State Association, any county society which may have a member involved, and the Oklahoma State Board of Medical Examiners to immediately have joint conferences to weigh the evidence that will be made available to them by the investigating committee in order that the physicians who may have been either rightfully or wrongfully involved in the hearings before the Committee may be either exonerated or disciplined. Your Council is firmly of the opinion that the public at large will not expect dilatory actions by the county society, the State Association or the Medical Board.

PROFESSIONAL ETHICS

The House of Delegates will recall that at the last meeting the activities of the Grievance Committee were discussed and commended and that in addition thereto the House of Delegates adopted an amendment to the Bylaws which provided for automatic terminations of membership of any member whose federal narcotic permit was revoked or suspended on conviction.

The Council also would point out for particular emphasis that part of the Public Policy Report which deals with medical testimony. It is the Council's firm opinion that this problem must be met and solved.

PUBLIC HEALTH

The Public Health Committee in its report will make recommendations in the fields of its following subcommittees: Rural Health, School Health, Blood Banks, and Industrial Health.

RURAL HEALTH

In regard to Rural Health, the Council commends to the House of Delegates the recommendations of the Public Health Committee that the Association and its Auxiliary in conjunction with farm groups of the State and other organizations interested in rural health, sponsor an annual Rural Health Conference, the first to be held sometime in the summer of 1953.

SCHOOL HEALTH

Your Council would call attention to the activities of the School Health Sub-Committee and wishes to emphasize that the general subject of school, or child, health, offers a fertile field for the development of satisfactory positive programs which can be of immense value to the public and the profession.

BLOOD BANKS

There is a general public interest in the availability of blood for civilian and military use which makes the activities of the Blood Bank Sub-Committee a most effective point of contact between the profession and the public and which emphasizes the necessity for development of some satisfactory blood banking plan in every community.

INDUSTRIAL HEALTH

As is pointed out by the Sub-Committee on Industrial Health, problems in this field are certainly not acute at this time but the far sighted activities of this Committee in attempting to anticipate the problems and recommend policies for their solution is indeed to be commended.

It is clear to the Council that in this period in which the profession can expect to be relatively free from governmental interference that the Association has the opportunity to achieve infinitely more in the way of betterment of health and medical care for the people than has been possible for many years due to the past pre-occupation with defense against governmental encroachment. The Public Health Committee, due to the diversity of its functions and activities, in cooperation with the Public Policy Committee, is the means through which these accomplishments can be made. Your Council therefore suggests that in the coming year the Public Health Committee redouble its efforts in its various fields of endeavor and that the component societies and the individual members of the Association cooperate fully with the Committee since that is the only way in which the efforts of the Public Health Committee can be made effective.

EDUCATIONAL COMMITTEE

While the Council is in complete agreement with the Educational Committee that the Association should, through the Committee, extend complete cooperation to the Post Graduate Office at the Medical School in the operation of its excellent Post Graduate courses, the Council wishes to emphasize that the Association must at all times be prepared to become active in the field of continuing medical education in view of the possibility that funds for this purpose may not continue to be available to the Medical School indefinitely.

CIVILIAN DEFENSE

With regard to the problem of Civilian Defense, your Council could point out to the House of Delegates that as long as five years ago the Association, at the request of the American Medical Association, took the leadership in bringing to the attention of the Governor of the State of Oklahoma the need for an adequate program for medical care in Civilian Defense.

Over the intervening years there has been so much confusion in this field that your Council has felt that any activity on the part of the Association should parallel State organizational activities through the State Civilian Defense Committee.

So far no firm program has been presented and the Chairman of the Committee who will report this afternoon has the support of the Council in his comments.

PREPAID VOLUNTARY HEALTH INSURANCE

In line with the Council's general observations concerning the future activities of the Association in promoting progress in health care, the place in American economy today of Prepaid Voluntary Medical and Hospital programs cannot be overlooked. The extent to which non-profit plans and insurance companies have developed the field of prepaid hospital and medical care has grown each and every year. Nevertheless, both non-profit plans and the commercial companies have repeatedly pointed out that the rate of admissions, medical fees and length of hospital stay of persons holding prepaid insurance contracts is solely in the hands of physicians and that unless the physicians accept their solemn responsibility as the comptroller of these plans and program they will either fail or the premium to be charged to the public will be so high that the substitution of Government insurance on a compulsory basis may become an economically advantageous step for Mr. and Mrs. America.

Already in Oklahoma it has been necessary for Blue Cross to restrict their plans in numerous groups and

communities, due to high utilization rates. Every effort must be made by county medical societies and the individual members to act in the best interests of not only the patient, but these types of plans.

In this field a Resolution was submitted by the Pittsburgh County Medical Society to have the Executive office act in the capacity of a group leader to allow all physicians not now covered by Blue Cross to have the privilege of enrolliug through the Executive Office. Your Council did not feel that it was necessary to accomplish this request by Resolution to the House of Delegates but that could be accomplished by Executive management and has instructed the Executive Office to negotiate with Blue Cross and have the privilege of enrolling through the Executive Office. Your Council did not feel that it was necessary to accomplish this request by Resolution to the House of Delegates but that it could be accomplished by Executive management and has instructed the Executive Office to negotiate with Blue Cross for the beginning of such a program. Due to the bookkeeping that will be involved, it is the Council's recommendation that the contract between the Association and Blue Cross be to cover all physicians not now covered and who are eligible, on an annual premium paying basis only and that the program begin by September 1, 1954. At the present time 628 physicians are enrolled in 69 different groups.

VETERANS MEDICAL AND HOSPITAL CARE

Recent publicity in the public press has pointed up the current interest in the manner in which veterans with non-service connected disability are being afforded Veterans Administration Hospital and Medical Care.

The Pontotoc County Medical Society has introduced a Resolution on this subject which your Council recommends for the serious consideration of the House of Delegates.

AMENDMENTS TO THE BY-LAWS

As a result of the general confusion which always exists in connection with nomination of Councilors and Vice-Councilors and in regard to the introduction of resolutions, your Council recommends the following amendments to the By-Laws.

AMENDMENT TO BY-LAWS

Amend Chapter V, Section 5, Page 42, by striking the present Section 5, and inserting in lieu thereof the following words and figures;

Section 5. Nomination of Councilors

(a) Nomination Petitions

The nomination of candidates for Councilor and Vice-Councilor for the Districts as provided for in Chapter IV, Section 1, shall be by nomination petitions from the Councilor Districts. Such petitions shall be signed by not less than five (5) active members in good standing in the District for which the nomination is made, and in all Districts containing more than one county such petitions shall contain the signatures of active members in good standing from at least three (3) different counties in the district.

At least ninety (90) days before each Annual Meeting the Executive Secretary shall notify each Component Society in each District for which Councilors and Vice-Councilors are to be elected of the fact that such election is to be held at the coming annual meeting and that nomination petitions must be filed in the Executive Office at least ten (10) days prior to the Annual Meeting in order for the nominees to be voted upon by the House of Delegates. The Executive Secretary shall also provide appropriate forms for the preparation of such nomination petitions.

(b) Election of Councilors

Election of Councilors shall be conducted as provided in Section 1, of this Chapter, except that no election shall be held to fill the office of Councilor or Vice-Councilor for which no nomination petition has been received. The office of Councilor or Vice-Councilor for which no nomination petition has been received shall be filled by election by the Council at a meeting called during the Annual Meeting, and Councilors or Vice-Councilors so elected by the Council shall be elected for a term covering the period from the Annual Meeting at which elected to the next Annual Meeting at which time the office shall be considered vacant and nomination petitions from the District shall be in order for the remainder of the prescribed three (3) Year term.

AMENDMENT TO BY-LAWS

Amend Chapter V, Section 2, Page 42, Lines 4 and 5, following the word "officers," strike the words, "Councilors and Vice-Councilors."

AMENDMENT TO BY-LAWS

Amend Chapter III, Section 6, Page 41, by striking the entire section and inserting in lieu thereof the following words and figures:

Section 6. Memorials and Resolutions

Any memorial or resolution issued in the name of the Oklahoma State Medical Association must be approved by the House of Delegates, except that the Council may approve memorials or resolutions when the House of Delegates is not in session. The House of Delegates shall consider only those memorials and resolutions which have been filed with the Executive Secretary at least thirty (30) days prior to the Session of the House of Delegates at which they are to be considered and which are signed by an active member in good standing of the Association or by the Secretary of a Component Society of the Association on behalf of the Component Society submitting such memorial or resolution. Memorials or resolutions may be referred by the Council to the House of Delegates for consideration by the House of Delegates without the necessity for prior filing as otherwise required by this section, provided, however, that any memorial or resolution to be presented to the Council after the thirty (30) days prior to the Session of the House of Delegates unless originated in and initiated by the Council, must be submitted to the Council by a Component Society and clearly show in the memorial or resolution that it has been approved for such presentation to the Council by the majority of the membership of the Component Society."

AMALGAMATIONS OF COUNTY SOCIETIES

In accordance with the long established policy of the House of Delegates, which recognizes the value to the profession and to the Association of combining county societies into amalgamation of the following:

Hughes-Seminole

SPECIAL MEMBERSHIPS

Nominations from the county societies for the various classifications of special memberships have been received by the Council in accordance with the provisions of the By-Laws and the Council recommends their election as follows:

Life Memberships

George S. Barber, M.D., Lawton
William LeRoy Bonnell, M.D., Chickasha
W. L. Cary, M.D., Reydon
E. S. Kilpatrick, M.D., Elk City
C. B. McMillan, M.D., Gracemont
O. A. Pierson, M.D., Woodward
W. E. Seba, M.D., Leedey
C. W. Tedrowe, M.D., Woodward
Ernest R. Vahlberg, M.D., Oklahoma City

Honorary Merbership

Roscoe C. Baker, M.D., Enid

Associate Membership

Carl R. Doering, M.D., Norman

CONCLUSION

Your Council would conclude this report by again emphasizing that it urges the profession to fight at all times complacency in Americanism and to at all times strive at the individual physician's level, the county society level and the State Association level, to bring better and more economical health care to the people.

At the conclusion of the Report, Shade Neely, M.D., Muskogee, moved, "That the name of Francis R. First, Sr., M.D., of Checotah, be included in the list for Life Memberships. Motion seconded and carried.

Charles Smith, M.D., Norman, Superintendent of the Central State Hospital, addressed the House and advised that the recent publicity coming out of the Central State Hospital involved the entire profession in Oklahoma and called attention to the fact that there were three Hospital superintendents present in the House of Delegates at that time.

Felix Adams, M.D., Vinita, Oklahoma, Superintendent of the Eastern Oklahoma Mental Hospital, addressed the House and spoke about conditions in Central State Hospital.

J. R. Colvert, M.D., Oklahoma City, also spoke regarding conditions at Central State Hospital. Doctor Colvert suggested that a Committee of doctors be appointed to study and inspect the State Hospital along with representatives of the Bar Association. The Speaker asked Doctor Smith, Superintendent of the Hospital, if he would be agreeable to such a Committee. Doctor Smith advised the House that such a Committee would meet with his approval.

W. S. Larrabee, M.D., Tulsa, moved: "That the Report of the Council be accepted." I. W. Bollinger, M.D., Henryetta, seconded and the motion carried.

The Speaker called for a report from the Public Health Committee. R. M. Madsworth, M.D., Tulsa, Chairman of the Committee, made the following report:

REPORT OF THE PUBLIC HEALTH COMMITTEE

The report of the Public Health Committee will be divided on the basis of the various Sub-Committees which as you will recall are: (1) Rural Health, (2) School Health, (3) Blood Banks, and (4) Industrial Health, and will be essentially as follows:

(1) *Rural Health*

The Public Health Committee upon recommendation of its Rural Health Sub-Committee, has approved plans for the organization of an Oklahoma State Rural Health Conference to be held under sponsorship of the Oklahoma State Medical Association in conjunction with the Oklahoma Farm Bureau of Federation, the Oklahoma State Dental Association, the Extension Service of both O. U. and A. & M., the Oklahoma Council of Home Demonstration Clubs, the Oklahoma Advisory Health Council, the Woman's Auxiliary to the Oklahoma State Medical Association and perhaps others.

It is planned that the Public Health Committee will bear the necessary expenses of the out-of-state speakers, the expense of meeting rooms, and arrangements for the Conference. It is estimated that these expenditures can be kept around $500.00, a sum which can be met from the Committee's present budget.

(2) *School Health*

The sub-committtee on School Health has been very active in the past year, and its present projected plans will, if approved, insure continuing activity in the field of School Health during the coming year. The Sub-Committee has joined with the State Health Department in the production of the film "School Health in Action," which has been made available to every County Medical Society in the State and to interested lay groups. This film has been very well received by the County Societies which have seen it, and it is the plan of the Committee to present this film to each County Society before it is shown to lay groups in the County.

The Committee is now working with the Health Department in the production of a second film to be entitled, "Well-Child Examinations." This film is more technical in nature than "School Health in Action" and is designed for the profession rather than for the lay public.

"The School Health Sub-Committee cooperated in the sponsorship of the School Health Conference in Norman last fall which was held in conjunction with the Annual Meeting of the Oklahoma School of Administrators and plans for the third such conference this year are now being formulated.

On approval of the Public Health Committee, the School Health Sub-Commitee is now preparing a child health record publication which it is planned will be distributed through the State Health Department to the parents of each live birth in the State of Oklahoma. This publication will contain general information in regard to child health for the use of the parents and immunization records and space for other health records, which the Committee feels are of sufficient importance to be included.

It is the belief of the School Health Sub-Committee and the Public Health Committee that satisfactory School Health Programs and child health information, made available through the Committee, can do much in the education of the public to the responsibilities of the parents, the physicians and the school in the overall problem of child health.

(3) *Blood Banks*

The Sub-Committee on Blood Banks has been guided by the principle that the problem can best be solved through the cooperative effort of the local Medical Societies, and other interested groups, and that each community can best solve its problem by the establishment of Blood Bank Plans which will best fit the needs of the community and the facilities which the community has to offer. In many of the smaller communities, the only practical plan is the so-called Walking Blood Bank, in some private facilities have been considered satisfactory and their use has worked out well in practice, while in others, banks operated in conjunction with the American Red Cross have been found desirable.

The Committee hopes in the coming year that it will be possible for it to make available to various County Medical Societies detailed information in regard to the establishment and operation of various types of Blood Banks, in order that some workable plan may be developed in every community.

(4) *Industrial Health*

The Sub-Committee on Industrial Health has found that Industrial Health problems in Oklahoma are largely projections into the future due to the predominately agricultural economics of the State. The Committee does, however, recognize the fact that a constant awareness of health problems as they develop rather than after they have existed for such a long period that their solution has become most difficult.

The Committee has reviewed legislation in the field of Industrial Health which has been introduced during the present session of the Legislature and has recommended to the Public Policy Committee of the Asso-

ciation its approval and support of a bill making occupational diseases compensable under the Workmen's Compensation Law provided such bill defines the occupational diseases to be covered.

The Public Health Committee has during the past year been working very closely with the Oklahoma Advisory Health Council which has been found so effective in other states in meeting the many health problems which cannot be solved by the profession alone, the lay public alone, nor any other single group, but which require the cooperation of every cross section of the community such as the establishment of County Health Units, the building of hospitals, the development of satisfactory School and Rural Health Programs. The Commitee has approved the expenditure from its funds of $500.00 to assist in the financing of the Oklahoma Advisory Health Council for the year. In that connection, it contemplated that some satisfactory method of financing the Council other than by donations from the various member organizations will be developed as the Oklahoma Advisory Health Council progresses and grows. In the meantime, however, it is the belief of the Public Health Committee that the medical profession in the State must continue to assist in the financial suport of the program of the Oklahoma Advisory Health Council and continue active in the development of its policies and its program.

The Public Health Committee can complete its 1953 program within its budget of $1,500.00 as allocated by the House of Delegates at its special meeting in 1953. It should be pointed out, however, that the expansion of the activities of the Public Health Committee during 1954, will be most important to the State Association since for the first time in many years, the medical profession now has an opportunity to embark upon a positive program of health betterment for the people rather than on a defensive program designed to defeat governmental encroachment on the practice of medicine. This Committee believes that any such positive program approved by the House of Delegates will to a great extent fall within the responsibility of the Public Health Committee which will necessitate consideration of some increase in the Committee's budget.''

At the conclusion of this report O. C. Standifer, M.D., Elk City, asked for a discussion under the School Health sub-committee, of the problem of injuries to school athletes. He asked that the Sub-committee on School Health investigate the insurance policies which the schools are carrying on their athletes from a Blue Cross standpoint and as a public service, this investigation to include private, public and parochial schools. This suggestion was referred to the School Health Subcommittee of the Public Health Committee.

I. W. Bollinger, M.D., Henryetta, moved: ''That the Report of the Public Health Committee be accepted.'' Motion seconded and carried.

The Speaker called for a Report from the Public Policy Committee. R. Q. Goodwin, M.D., Oklahoma City, made the following Report:

PUBLIC POLICY COMMITTEE REPORT

The Public Policy Committee has been mainly concerned during the past year with the problems that have been and will be presented with the change of Government Administration at the National level and the activities of the Oklahoma Legislature.

Your Committee herewith presents a brief resume of these two problems and its activities:

FEDERAL LEGISLATION

Your Committee commends the American Medical Association's Committee on Legislation for the excellent job it is performing in reporting legislation before Congress.

Among the bills now pending before Congress are measures dealing with Veterans Hospital Care, Federal Aid to Education, Subsidization of Health Insurance Plans, Tax Relief, Hospital Construction, etc.

Your Committee is not in a position to duplicate the services or evaluate these bills in the same manner as the A. M. A. Your Committee nevertheless has at all times cooperated with the A. M. A. in contacting our Oklahoma delegation concerning such legislation.

Your Committee does feel that there are two measures now before Congress that should have the immediate attention of all physicians.

These two measures are the H. R. 10, by Rep. Jenkins of Ohio and Rep. Keogh of New York and S. J. R. No.1, by Senator Bricker of Ohio. This first measure gives tax relief to self-employed to create their own retirement by allowing deductions from their net income of 10 per cent or $7500.00, whichever is the lesser, and the latter proposes an amendment to the Constitution of the United States whereby International Agreements or Treaties shall not abridge the rights enumerated in the Constitution nor any other rights provided by Federal laws. This amendment will take away the force and effect of past agreements entered into with the International Labor Organization that has been attempting to sponsor Socialized Medicine from outside the borders of the United States.

Your Committee also endorses the resolution from Pontotoc County which will be introduced concerning Veterans Medical Care for Non-Service Connected Disabilities.

STATE LEGISLATION

Each delegate has been furnished with a copy of the bills before the Oklahoma Legislature. Two typographical errors should be corrected; these are H. B. 516, which should be reported as neutral and S. B. 338, which should be reported supported. Your attention is directed to all bills dealing with narcotics which have been supported. While there has been support of these bills, your Committee recognizes that there is certain duplication in these bills and that before there is adjournment, there must be conferences held on these bills. To this end your Committee is submitting the following Resolution. (READ only NOW THEREFORE BE IT RESOLVED.). Your Committee would also point out that no legislation has been introduced as yet by the investigation committee on the Central State Hospital. However, your Committee recognizes the responsibilities of the profession concerning mental health care and submits the following resolution. (See second session of the House of Delegates for resolution) These questions and, the final resulting legislation, your Committee feels must be worked out between Committees of the Legislature and all other groups of the healing arts and the pharmacy profession that will be affected.

Your Committee also points out that all legislation requested by the State Board of Medical Examiners has been supported, passed and is now law.

Although other bills appearing on the list of proposed legislation have been either supported, opposed or a neutral position taken, there is still one measure that has not been settled as to the Association's position; this is H. B. 953, which only affects physicians dispensing eye glasses and dispensing opticians. On this bill your Committee has called a meeting for tomorrow of these physicians in order that they may express their opinions.

Your Committee will continue to give every consideration to legislation being considered by the Legislature

and make recommendations that it deems to be in the best interest of the public.

Recognizing that the sole function of your Committee is not in field of legislation, your Committee is in complete agreement with both the Council and the Committee on Public Health that the next four years should and must be the years in which the medical profession will show its leadership in health care. Predicated on this assumption, your Committee recommends the following Public Policy Programs:

1. In cooperation with the Public Health Committee, promote the following:
   - A. Rural Health Programs of Medical Care.
   - B. Establish better relations between the profession, hospitals and Voluntary Health Programs.
   - C. Establishment of medical care for areas not now served by the profession when relocation of physicians cannot be accomplished.
   - D. A continuation of support of the University of Oklahoma Chapter of the Student American Medical Association.
   - E. A vigorous campaign to bring about a change in the manner in which medical testimony is given before the Corporation Commission and the Courts.
   - F. A continuous program to bring about better medical care for veterans but not at the expense of the taxpayer for non-service connected disability.
   - G. A more harmonious and better relationship with the Allied Professions.

With regard to paragraph "E" of these recommendations, your Committee recognizes that it has not accomplished the recommendations of the January meeting of the House of Delegates. Your Committee, and your President met with Attorneys of the Association on this problem and felt that legislation in this field would require more study. Your Committee, however, recognizes the interest of our President, Doctor Sugg, on this subject and wishes to report that in addition to the proposed legislation Doctor Sugg has contacted the Chairman of the Industrial Commission, Mr. Tom Hieronymous, and negotiations are now under way to write this legislation in cooperation with the Industrial Commission. Your Committee would also point out that Mr. Hieronymous will discuss this problem on the symposium on Industrial Medicine Wednesday afternoon.

Your Committee recognizes the extent of its responsibilities and respectfully requests that all members and the County Societies realize that success in the public relations field will only succeed in ratio to the individual members participation.

After considerable discussion with regard to various legislation, including the Free Choice of Physician under the Compensation Law, the Right to Work Legislation, etc., J. R. Colvert, M.D., Oklahoma City, moved that the Report of the Public Policy Committee be accepted. Motion seconded and carried.

The Speaker called for a report from the Scientific Work Committee. Berget H. Blocksom, M.D., Tulsa, Chairman of this Committee, made the following report:

REPORT OF CHAIRMAN OF SCIENTIFIC WORK COMMITTEE

"Mr. Speaker and Delegates:

"Your Scientific Work Committee is requested to report to you on the forthcoming program for the state meeting starting tomorrow.

"We feel that we have arranged an outstanding program and since you are all provided with a program all that remains is the 'proof of the pudding.' We would like to point out a slight innovation from recent years. This is the addition of panel group meetings running concurrently with the afternoon general sessions. Actually we had such a wealth of material, thanks to the splendid response of our members to the appeal for scientific titles, that we could accommodate but a fraction of these titles even by the addition of three extra afternoon sessions. Of special interest should be the Wednesday afternoon panel on Industrial Medicine featuring in addition to the medical papers, one on evaluation of Medical testimony before the Oklahoma State Industrial Commission by Judge Hieronymous. This meeting will be the only one held at the Mayo so as to allow the exhibitors to pack up. We felt that with the ever increasing amount of industry with its attendant medical problems and problems of jurisprudence in connection with it, that such a panel deserved special attention and would be important to our colleagues in all parts of the state. Because of other considerations, including the schedule of our guest speakers, it became necessary to have this important session on the final afternoon, and we urge you here that are interested not to only attend, but to 'talk it up' to our colleagues.

"As always happens, we had to pass over many excellent titles submitted by our members. It is necessary to emphasize again our gratitude for their contributions and to let our members whose papers were not selected know that the only limitations lie with the length of the meeting and the available space.

"I want, finally, to personally thank you for your confidence in me in selecting me for this responsible assignment and to thank you again for your cooperation."

At its conclusion, I. W. Bollinger, M.D., Henryetta, moved that the report be accepted. Motion seconded and carried.

The Speaker called for a Report from the Organizational Committee. L. C. McHenry, M.D., Oklahoma City, made the following report.

REPORT OF ORGANIZATION COMMITTEE

(Including Subcomittees on Budget and on Insurance)

Finances

Your Committee believes that the financial condition of the Association is healthy. However, during the fiscal year 1952, there was an excess of disbursements over income of slightly more than $3,000.00. This deficit was due to the extraordinary legal expenses authorized by the House of Delegates during 1951.

The Association owns government bonds in the amount of $12,398.00, and has an operating cash reserve of approximately $35,000.00. This does not include any 1953 income. It is not possible at this time to estimate the income for 1953, let alone 1954, with accuracy because the dues of many members, although technically delinquent, have not yet been paid. Also income and expense items from the operation of the Journal and from the Annual Meeting cannot yet be tabulated. It is the feeling of your Committee that more exact evaluation of the financial condition of the Association will be possible when the new method of accounting voted by the House of Delegates in January has been in use for at least one year.

There has been considerable discussion among members of the Council and the Committee regarding investment of the surplus funds of the Association. The acquisition of property for a permanent headquarters for the Association offices has been proposed. Another proposal has been for the establishment of a Loan Fund for needy medical students. If not invested in some such fashion, the greater part of the surplus funds

should be placed in government bonds and drawing interest. The Committee recommends that the House of Delegates direct the Council to take some definite action in regards to this matter.

The Committee is of the opinion that there probably will be a small operating surplus at the end of 1953, in spite of some considerable items of increased expense which the Committee has recommended and the Council has ordered. These items are:

1. Renovation of filing and bookkeeping system. Should cost less than $500.00.
2. Salary increases.
3. Retirement Pension Plan for employees. The Committee has studied plans submitted by several insurance companies and has recommended the adoption of one to the Council.

The plan recommended for a monthly pension for each employee at age 65. The amount of the pension will vary from a lower limit of $50.00 per month to an upper limit of $215.00 per month, depending upon the salary and upon the length of time employed by the Association. The employees' contribution towards the cost of the plan will be three per cent of each employee's salary. This will amount to between one-fifth and one-fourth of the total cost. The cost to the Association will average approximately $3000.00 per year over the first five years. The initial premium, to be paid when the plan is started, will be slightly more than $4,000.00. This will of course be partly repaid by employee salary deductions from month to month.

The preparation of a recommended budget for the year 1954 is a matter of approximation and guess work as it has been for many years. The Committee presents the following budget for your consideration.

Proposed Budget for Year 1954

Estimated Income	
Dues (1350 members at $42.)	$56,800.00
Interest, U. S. Bonds	250.00
Annual Meeting (Deficit)	
Journal (Deficit)	
Miscellaneous	
Rent (SW Surg. Cong.)	
Commission for collecting AMA dues	337.50
Total Income	$57,872.50
Estimated Expenses:	
Office expenses	$30,100.00
Annual Meeting Deficit	2,500.00
Journal deficit	4,600.00
Public Policy Committee	2,500.00
Public Health Committee	1,500.00
Postgraduate Committee	500.00
Retirement Pension Plan	3,000.00
Legal Expense	1,200.00
Out of State Travel	6,000.00
	$51,900.00
Miscellaneous and/or possible addition to surplus	$57,872.50

Since the termination as to the investment of surplus funds and as to the advisability of accumulating further surplus funds is a matter of broad Association policy, the Committee recommends that the annual dues for the year be set at $42.00, the same as the previous few years. When the above broad matters of policy are determined and when and if, more accurate methods of predicting income and expense are attained, some adjustment of the amount of the annual dues will probably be advisable.

With regard to the Malpractice Insurance Master Policy of the Association held with the Saint Paul Mercury Indemnity Company, the first anniversary date of the contract will be June 15, 1953, at which time the Company will render a report of its first year of operation.

At the present time it would appear that the majority of the members of the Association have taken advantage of the program and the experience of the Company has been favorable.

At the conclusion of the Report the Speaker called the attention of the House to the fact that if this Report were approved in one motion, it would include the following items:

1. Direct the Council to take some definite action in regard to the surplus funds.
2. Include expenditures for renovation of the filing system, salary increases and Retirement Pension Plan.
3. Set the dues for 1953-54 at $42.00.
4. Approve the Proposed Budget for 1954.

J. R. Colvert, M.D., Oklahoma City, moved: "That each item of the Report be discussed and voted on separately at the evening session." Motion seconded and carried.

Doctor McHenry passed out copies of the Report to the Delegates for their further consideration.

The Speaker called for a Report from the Postgraduate Commitee. Harry Daniels, M.D., Oklahoma City, made the following Report:

EDUCATIONAL COMMITTEE REPORT

Your Educational Committee in attempting to analyze the reasons for such small attendance at the last post graduate sessions conducted by the Committee and the Post Graduate Division of the Medical School in 1952, could attribute the poor attendance to six factors:

1. The great number of medical meetings of all types, including hospital staff meetings.

2. The almost continuous post graduate programs being offered at the Medical School which have been of the highest quality.

3. Outstanding courses in post graduate education in adjoining and nearby states.

4. The difficulties for most of the profession involved in attempting to attend meetings in their own communities where they must be constantly on call.

5. The very natural attitude that the best programs are those offered in a more academic atmosphere such as the medical school or other medical centers.

6. The general dissatisfaction with lecture type programs.

On the basis of the above items your Committee has concluded that for the time being it can work most effectively by cooperating with the post graduate office of the Medical School in the promotion of the programs which are being offered by the School.

At the present time it is contemplated that efforts will be made to organize practitioners conferences of the type that have been most sucessful on the Medical School campus and take these conferences to the physicians of the state. It is not planned that these conferences will be organized on a regular circuit basis but rather that arrangements will be made through county medical societies which are willing to co-sponsor such conferences and take the responsibility of inviting the physicians in adjoining counties to meet with them for the practitioners conferences. The details of arranging these meetings and providing for the participation will be handled jointly by the Post Graduate Office and the State Medical Association and it is the hope of the Committee that sufficient local interest can be generated

throughout the State to justify a number of meetings of this type each year.

While the relations of your Education Committee with the Post Graduate Office of the Medical School have always been most cordial and satisfactory it is the belief of the Committee that it or some other committee of the Association should be delegated the responsibility of attempting to bring into being a much more effective liaison between the Oklahoma State Medical Association and Medical School of the University of Oklahoma. It is believed that if such means of accomplishing this objective can be developed, that it would be of immeasurable benefit both to the Medical School and to the membership of the State Medical Association. Situations constantly arise in which the State Association could be of great assistance to the Medical School and likewise in which the medical school could be of great service to the members of the profession of this state and your Committee suggests that steps be taken to authorize consultation with the faculty and administration of the medical school in order that this liaison between the two organizations may be brought about.

I. W. Bollinger, M.D., Henryetta, moved: "That the Report be accepted." Motion seconded and carried.

The Speaker called for a Report from the Committee on Civilian Defense. In the absence of Gifford Henry, M.D., Tulsa, no report was forthcoming.

Doctor Gallaher announced that the colored physicians of the State had been invited to attend the Scientific Sessions as guests of the Oklahoma State Medical Association.

Doctor Gallaher called for a report from the Grievance Committee. C. E. Northcutt, M.D., Ponca City, Chairman of the Committee, made the following Report:

REPORT OF THE GRIEVANCE COMMITTEE

Any statistical summary of the activities of the Grievance Committee is necessarily inadequate to describe the activities of the Committee for a given year. In spite of that fact, the Committee does feel that there is some value to a classification of the cases and a report as to the number received, pending and closed.

The Committee began the year 1952-1953 with four cases pending which had been filed in the previous year. It is encouraging to note that during the year covered by this report only 16 new cases were presented to the Committee, and that 16 of the 20 cases which the Committee has had pending during the year have been closed, leaving a balance of four cases now pending which will be carried over into the next year.

The 16 cases filed during the past year may be classified as follows for the information of the House of Delegates:

Cases concerning the fee only	5
Cases concerning service only	3
Cases concerning both fee and service	6
Case concerning Blue Cross-Blue Shield Utilization	2
TOTAL	16

The House of Delegates should be advised that in one instance on request of the Medical Staff, Board of Control, and the Blue Cross-Blue Shield Plan, the President of the Association asked the Committee to investigate the Blue Cross utilization in one of the hospitals of the State, and in that investigation to review the hospital records for each individual patient for a given period.

The Committee, in its report of this investigation emphasized the responsibility of both the patient and physician in regard to Blue Cross-Blue Shield utilization.

Consideration of this situation has been completed as a result of a joint meeting with the Hospital Administrator, representatives of the Medical Staff, and of the Board of Control.

The additional case carried in the classification above as being one of Blue Cross-Blue Shield utilization arose out of the investigation mentioned and has been settled by a refund to Blue Cross of $500.00.

Your Committee does not feel that one or even several years of experience in the handling of Grievances is sufficient to draw any satisfactory conclusions as to the number of cases which may be expected on the average. It is, however, interesting to note that the number of cases filed with the Committee during the past year is 20 per cent less than were filed during the previous year. The Committee is further of the opinion that the very existence of the Committee exercises a wholesome effect on the relations of patients and physicians.

T. H. McCarley, M.D., McAlester, moved that the Report be accepted. Motion seconded and carried.

John Burton, M.D., moved: "That the State Office be instructed that in the future whenever a doctor wishes to become a member of the Association and submits application for new membership, he shall be furnished with one of the Plaques, "To All My Patients" without charge. R. Q. Goodwin, M.D., seconded and the motion carried.

The Speaker called for a Report from the Committee on Military Affairs. In the absence of F. Redding Hood, M.D., Oklahoma City, Dick Graham made the report. Mr. Graham advised that the recent action of Selective Service had made the report that had been prepared for the Military Affairs Committee obsolete but that the gist of the new regulations was as follows:

All Priority I and II physicians will continue to be inducted into the Military Service on their availability, irrespective of age. All Priority III physicians born before August 31, 1922, if under orders for pre-induction, their orders will be cancelled or if under Induction Orders, they will be cancelled. Those who volunteered for Service, their Orders will be cancelled if they wish. If, however, having disrupted their practices and homes, they prefer to go on in, they may do so. Mr. Graham advised further that this cutback has been predicated upon the fact that Selective Service and the Department of Defense want to see just exactly how many doctors and interns and residents will be available July 1; that they think there will be enough available to take care of the immediate needs of the Military Forces. This action of Selective Service cannot be taken as a permanent thing. He also advised that all Priority I's and II's who had previously been disqualified would be re-examined.

It was moved, seconded and carried that this Report be accepted.

The Speaker next announced that it was now in order that any amendments to the Constitution and Bylaws be presented from the Floor. None were forthcoming.

Doctor Gallaher called for any unfinished business from the last meeting of the House of Delegates. None was brought up.

The Speaker announced that Resolutions would be accepted from the floor. He suggested that they be presented by title at this time, to be presented to the Resolutions Committee and read at the final session in the evening.

M. O. Hart, M.D., Tulsa, presented a Resolution on STANDARDIZING, SHORTENING, AND SIMPLIFYING MEDICAL AND HOSPITAL INSURANCE PLAN FORMS.

Doctor Gallaher announced that the medical film YOUR DOCTOR would be presented that evening, emmediately preceding the final session.

The Speaker then asked Keiller Haynie, M.D.,, Durant, Alternate Speaker of the House of Delegates, to take the Chair and read the Necrology Report. The Report was as follows.

Since the last Necrology Report in May, 1952, the Almighty, in His Infinite Wisdom has called from our midst 49 of our beloved friends and co-workers. While we bow in sorrow to the will of the Omnisience, we are appreciative of these wonderful men—physicians, scientists, teachers and friends, and their far-reaching influences which will continue to inspire us to carry on their duties to humanity.

THEREFORE, BE IT RESOLVED that the House of Delegates of the Oklahoma State Medical Association recognize the demise of those former 49 fellow physicians and instruct the Secretary to inscribe with honor and regret the following names upon the records of the Association:

Thomas P. Allison, Sand Springs ..... August 1, 1952
A. M. Arnold, Claremore ..... October 20, 1952
Ernest Ball, Sulphur ..... September 20, 1952
E. Eldon Baum, Oklahoma City ..... May 16, 1952
G. L. Berry, Lawton ..... May 27, 1952
J. C. Best, Oklahoma City ..... November 4, 1952
Jesse L. Blakemore, Muskogee ..... November 4, 1952
R. A. Brown, Prague ..... March, 1953
John R. Callaway, Pauls Valley ..... November 3, 1952
J. S. Chalmers, Sand Springs ..... March 23, 1953
F. R. First, Sr., Checotah ..... January 31, 1953
Thomas Gordon Forsythe, Allen ..... November 8, 1952
George Fulton, Oklahoma City ..... July 1, 1952
David Gillick, Talihina ..... April 30, 1952
K. D. Gossom, Clinton ..... May 15, 1952
D. W. Griffin, Norman ..... January 2, 1953
W. F. Griffin, Watonga ..... March 11, 1953
Walter W. Groom, McAlester ..... October, 1952
Charles H. Haralson, Tulsa ..... January, 1953
I. V. Hardy, Medford ..... January 17, 1953
Kenneth D. Jennings, Chelsea ..... August 2, 1952
Carroll Allen Johnson, Healdton ..... September 14, 1952
E. T. Keeler, Lamont ..... July 28, 1952
J. A. Kennedy, Okmulgee ..... September 12, 1952
Robert Keyes, Ada ..... February 26, 1952
William H. Kingman, Bartlesville ..... September, 1952
Clarence Edward Lee, Oklahoma City, December 6, 1952
R. C. McCreery, Erick ..... October 12, 1952
James F. McMurry, Sentinel ..... August 11, 1952
William G. McPherson, Okla. City ..... December 13, 1952
Robert L. Mitchell, Vinita ..... May 17, 1952
B. H. Moore, Oklahoma City ..... August 31, 1952
Peter G. Murray, Tulsa ..... August 25, 1952
O. C. Newman, Shattuck ..... March 14, 1953
Julius William Nieweg, Duncan ..... February 17, 1953
E. E. Norvell, Oklahoma City ..... April 21, 1952
John S. Pine, Oklahoma City ..... July 4, 1952
D. D. Roberts, Enid ..... March 2, 1953
Edward D. Rodda, Okmulgee ..... December 28, 1952
R. H. Sherrill, Broken Bow ..... July 1, 1953
Andrew Jackson Snelson, Checotah ..... May 4, 1953
Robert C. Tavlin, Okeene ..... November 30, 1952
Ernest Thomas, Quinton ..... May 8, 1952
William A. Tolleson, Eufaula ..... January 24, 1953

Following this, the meeting was adjourned to reconvene at 7:30.

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CURRENT ACTIVITIES AT THE OKLAHOMA MEDICAL RESEARCH FOUNDATION

EDWARD C. REIFENSTEIN, JR., M.D.
DIRECTOR



This, the 19th article in the present series, will discuss the current activities of the dietitians of the Research Hospital, which is part of the Oklahoma Medical Research Foundation.

The dietetic staff, under the direction of Miss Shirley L. Wells, Director of Dietetics, has had the responsibility of serving three meals a day to the patients throughout their entire hospital stay. Although initially there were some handicaps because of a shortage of personnel, the Dietetic Section at the present is adequately staffed and able to meet the demands of the research program.

At the time this article is being written, there have been 51 admissions of 45 in-patients. These individuals have stayed in the hospital for periods of from one full day to as long as 247 days. All of the patients have been subjects for metabolic studies, and about 50 per cent of them have been on metabolic balance regimens, which have varied in length from three to 245 days. The three balance studies that have been completed have lasted 49, 128, and 131 days respectively. Two of the balance studies in progress at present were started during the first week of January, 1953, and two others were started about the middle of February, 1953.

All of the patients who have been on metabolic balance studies, with the exception of two, have been on dietary regimens in which the food was derived from natural sources. Some comments concerning the source of foods that are employed in such balance studies may be of interest. To a large extent, canned foods are used. However, the meat, of as high a quality as possible, is obtained from a reliable butcher; fat, gristle, and connective tissue is carefully removed; and then it is ground three times. Next, it is thoroughly mixed and weighed into individual portions. The quantity prepared at one time is usually that which is estimated to be sufficient to meet the anticipated length of of the metabolic study. When the individual portions are prepared, they are then frozen and are kept in a deep freeze until needed. After a considerable search, the Director of Dietetics discovered a farm where the hens were being fed very consistently a scientifically balanced diet, and arrangements were made to secure the eggs that are used from this source. All the water that is furnished to the patients is chilled distilled water. All other liquids supplied to the patients, including frozen orange juice and coffee, are made under standard conditions and with distilled water.

From time to time, a complete aliquot of the meals that are being served to each patient is weighed out, prepared in other ways by the dietitians, and sent to the laboratory for analysis. At the time this article is being written, 61 samples of diets have been sent to the Central Research Laboratory for determination of the protein and the mineral content. It may be of interest to point out that the actual analysis of the meat available to the Research Hospital shows a higher protein content than was indicated by the tables. The difference is sufficiently great so that an allowance must be made for this in estimating the diet when the design of a metabolic balance experiment is being developed. Bread for low calcium diets has to be made in the Research Hospital from a special formula, since commercially available breads have added to them milk powder, mold preventive and other substances which contain calcium.

Since Miss Wells, the Director of Dietetics, and the graduate dietitians on her staff form such an integral part of the team which conducts clinical investigation in the Research Hospital, we will take a moment to introduce the Dietitians briefly. Miss Wells has been presented to our readers in a previous article in this series (J. Okla. State Med. Assoc. 45:28-30 (January) 1952).

Miss Helen Hamra was born in Bristow, Oklahoma, and was graduated from highschool there. She received a Bachelor of Science degree in Household Science with a major in Foods and Nutrition from Oklahoma A & M College in 1947. She was awarded a Master of Science degree in 1948 from the University of Iowa, where she took her dietetic internship under Dr. Kate Daum, and prepared a thesis on "The Recovery of Mineral Oil and Vitamin A from the Feces." Miss Hamra is a member of the American Dietetic Association and of the Oklahoma Dietetic Association. She joined the staff of the Research Hospital on September 1, 1952.

Miss Sharon Orrick was born in Booneville, Arkansas. She completed highschool in Booneville, and attended Arkansas Polytechnic College in Russellville, Arkansas for two years. Miss Orrick was graduated in 1951 from the University of Arkansas, Fayetteville, Arkansas, where she was awarded a Bachelor of Science degree in Home Economics with a major in Foods and Nutrition. Subsequently she had further training in Dietetics at the University of Oklahoma Hospitals and at the University of Maryland Hospital in Baltimore, Maryland. Miss Orrick is a member of the American Dietetic Association and of the Oklahoma Dietetic Association. She joined the staff of the Research Hospital in February, 1953.

In addition, the Dietetic Department is assisted from time to time by Mr. A. C. Roberson, a junior medical student, and Mr. Robert Herrin, a sophomore medical student at the University of Oklahoma School of Medicine, and Miss Melba Lowder, a senior at Northeast High School in Oklahoma City.

The dietitians participate in Grand Rounds on Friday mornings with the physician members of the Research staff and the senior members of the Laboratory Divisions. The dietitians also attend regularly on Friday afternoon the weekly Seminar which is given for the members of the Research staff and for all others who are interested.

Although the Dietetic Section of the Research Hospital has adequate personnel at present to take care of the number of patients which are under investigation, the potential capacity of the Hospital has not been reached, and ultimately there will be a need for additional dietitians to participate in the important and interesting research program of the Foundation. Any graduate dietitian who is interested in being considered for a position in the Research Hospital should contact Miss Shirley L. Wells, Director of Dietetics.

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OBITUARIES

J. R. BARRY, M. D.
1870-1953

J. R. Barry, M.D., Picher physician, died April 29 at his home in Miami.

Doctor Barry, who had practiced 28 years at Picher, had been awarded the O.S.M.A. 50 Year pin. He began practicing in Carterville, Mo. after graduating from the American Medical College, St. Louis, in 1899. At Carterville, he was mayor two terms.

Doctor Barry was a Mason and a member of the Picher Lions Club.

Survivors are the widow of the home, a son, George N. Barry, M.D., Oklahoma City; a daughter, Mrs. Margaret Whittemore, East Lansing, Mich.; a brother, John Barry, Wichita, Kansas; two sisters, Mrs. S. Maxwell Smith, Tulsa, and Mrs. Ella Whitelock, Litchfield, Ill., and three grandchildren.

WENDELL J. WHITE, M. D.
1923-1953

Wendell J. White, M.D., staff physician at the Eastern Oklahoma State Hospital at Vinita, died May 11 of a heart attack brought on by exhaustion.

Doctor White, who had been on the staff of the hospital since August 4, 1952, was a graduate of the Arkansas Medical School and was a veteran of World War II. He was a native of Quanah, Texas.

Survivors include the widow of the home, four children, his parents, one brother and one sister.

APPOINTED TO SMA COUNCIL

Henry H. Turner, M.D., Oklahoma City, has been appointed a member of the Council of the Southern Medical Association from Oklahoma for a regular term of five years, beginning at the close of the annual meeting in Atlanta, Georgia, in late October.

The appointment was recently announced by the President-Elect, Alphonse McMahon, M.D., St. Louis, Missouri. Doctor Turner succeeds Fred E. Woodson, M.D., Tulsa, whose term will expire with the close of the Atlanta meeting. Doctor Woodson was not eligible for reappointment as he had served the constitutional limit.

PR INSTITUTE SET FOR SEPTEMBER

Outstanding postgraduate courses in medical public relations will be offered at the AMA's second Public Relations Institute for all state and county PR personnel. "Classes" will convene September 2 and 3 at Chicago's Drake Hotel.

Topics such as medical forums presented by medical societies in cooperation with local newspapers and tips on how to conduct sucessful public relations programs on limited budgets will be discussed by authorities in the field. In addition, emphasis will be placed on the use of television as a PR medium. Especially-filmed shows available for use by local medical societies will be given a preview at the Institute.

Designed primarily for lay public relations employees of state and county medical societies, the program will include both talks by PR experts and bull-sessions to give each registrant a chance to solve his special local problems.

FIGHTIN' TALK

Four Oklahoma Physicians have entered service while three have been released. They include the following:

ENTERED SERVICE

James O. Asher (Maj.), Altus, reported to Gunter Air Force Base, Montgomery, Ala., for five weeks, then to the Far East.

Thomas D. Howard (Lt.), Idabel, reported to Gunter Air Force Base, Montgomery, Ala.

James R. McLauchlin, Jr. (Capt.), Oklahoma City, reported to Camp Pendleton, Wash. for two weeks, leaving May 27 for Japan.

Jose Rafael Rigual (Lt.), Wister, reported to Fort Sam Houston, San Antonio, Texas.

RELEASED FROM SERVICE

Carl Bowie, M.D., formerly of Bristow, now located in Pauls Valley.

J. N. Byrd, Jr., M.D., reopened his offices in Pauls Valley.

Walter Cale, M.D., reopened his offices in Sapulpa.

New Booklet For All AMA Members

How the AMA may serve you . . . as one of its members . . . is the theme of a new pamphlet which the American Medical Association will publish this summer. Designed to acquaint members with the AMA's many activities and services, "It's Your AMA" will be mailed to every member, and, thereafter, will be sent to each new member of the Association.

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SEPTEMBER 28 THRU OCTOBER 1, 1953

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Surgeon, Lahey Clinic

John V. Goode, M.D., F.A.C.S., Dallas
Professor, Surgery, Southwestern Medical School

Philip J. Hodes, M.D., Philadelphia
Professor, Radiology, University of Pennsylvania

J. Hewitt Judd, M.D., F.A.C.S., Omaha
Professor, Ophthalmology, University of Nebraska

Joseph B. Kirsner, M.D., F.A.C.P., Chicago
Professor, Medicine, University of Chicago

Francis D. Murphy, M.D., F.A.C.P., Milwaukee
Clinical Professor, Medicine, Marquette University

Alton Ochsner, MD., F.A.C.S., New Orleans
Director, Surgical Division, Ochsner Clinic

Doctor Ochsner will deliver the Edward Holman Skinner Memorial Lecture

Irvine H. Page, M.D., F.A.C.P., Cleveland
Director of Research, Cleveland Clinic Foundation

J. H. Randall, M.D., Iowa City
Professor Obstetrics and Gynecology, Iowa State University

Herbert Rattner, M.D., Chicago
Professor, Dermatology, Northwestern Medical School

Stanley P. Reimann, M.D., F.A.C.P., Philadelphia
Asst. Professor, Experimental Pathology, Univ. of Penna., Grad. School

William L. Rienhoff, Jr., M.D., F.A.C.S., Baltimore
Associate Professor, Surgery, Johns Hopkins

Paul V. Woolley, Jr., M.D., Detroit
Professor, Pediatrics, Wayne University

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....., **1953**

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This page, given here to the encouragement of post-graduate clinical education, serves medicine at other times through the messages on drug and liquor addictions of the Ralph Sanitarium, 529 Highland Avenue, Kansas City 6, Missouri. Telephone: VIctor 3624.

BOOK REVIEWS

BONE TUMORS. Louis Lichtenstein, M.D., C. V. Mosby Company, St. Louis. 1952.

This book will prove to be of great value to orthopedic surgeons, radiologists and pathologists alike. It is based on many years of personal experience of the author as pathologist in a large orthopedic hospital and on a large number of pioneering papers in which the author, together with H. L. Jaffee, has first described or renamed such bone lesions as osteoid osteoma, fibrous dysplasia, chondromyxoid fibroma, benign chondroblas,-toma, non-osteogenic fibroma, eosinophilic granuloma, aneurysmal bone cysts, etc. The author correctly stresses the great importance to consider clinical data, age of patient, location of lesion, radiologic appearance but he also emphasizes that ultimately the diagnosis of such lesion must be based on the microscopic examination of a biopsy. Such biopsies must precede any therapeutic intervention, surgical or radiologic, since X-ray findings can only rarely be considered equivocal for certain bone lesions. The author disputes the specificity of such radiologic signs as periosteal onion peel layers to denote Ewing's tumor; as perpendicular striations to denote osteogenic sarcoma; or as soap bubble-like multilocular cysts to denote giant cell tumor.

In stressiug the importance of biopsies, the author also stresses the importance of correct histologic interpretation and warns against over or under-diagnosing bone lesions. He states candidly that "the skeleton is regarded by many pathologists as a sacred cow" and points to the importance of minute histocytologic examinations. This is of paramount importance to distinguish between chondromas and chondrosarcomas; between benign and malignant giant cell tumors; between osteogenic sarcomas and fibromas, et al. The book furnishes expert guidance to pathologists to come to correct diagnostic conclusions in old as well as in the newly created pathologic entities. It introduces grading of giant cell tumors on histologic grounds.

One chapter is devoted to the important differential diagnosis between primary and metastatic bone lesions and between neoplastic and non-neoplastic lesions. Here again, minute microscopic examination of the biopsies as well as general clinical and radiological considerations are essential for the diagnosis. Such lesions as fibrous dysplasia, eosinophilic granuloma, unicameral cysts and generalized osteitis fibrosa cystica have to be considered. The importance of these statements cannot be emphasized too strongly. The reviewer is reminded of a case in which "recurring" brown nodes of generalized osteitis fibrosa cystica were mistaken for metastases of a malignant giant cell tumor and radical surgery contemplated until finally attention was paid to blood chemistry and to the finer histological details of excised tissue and a parathyroid adenoma looked for, found and removed. The author stresses the relative frequency of metastatic bone lesions, which is much greater than is generally realized occurring in a great variety of primary neoplasm.

The classification given by the author is straightforward, simple and useful. It would perhaps be desirable to include discussion of odontogenic tumors in a new edition. A brief discussion of histological techniques in decalcifying, cutting and staining bone tissue also would be very useful to pathologists.

Some statements seem to be perhaps too categorical, such as the author's strict belief that fibromas never become malignant—a statement contrary to the experience of Stout and Willis—or a statement that in the author's experience endchondromas of ribs have never been encountered. Actually, this location is not at all rare as on finds in the much larger series of tumors suplied by Geschickter and Copeland.

The author also appears to be somewhat too confident in his statement that he can differentiate between Ewing's sarcoma and reticulum cell sarcoma of bone, a feat which neither Stout nor Willis, two of the world's most experienced oncologists, claim to be able to achieve. The difficulty to distinguish between these two lesions is simply caused by the fact that they are very closely related. The author does not deny this fact but has not succeeded in clarifying the issue since he relates the the origin of both tumors to reticulum cells. It seems to this reviewer that Ewing's sarcoma originates from the most primitive reticulum cells of the marrow, which perhaps differentiate towards primitive free marrow blast cells; whereas in reticulum cell sarcoma of the bone, there is some differentiation towards reticuloendothelial cells, a fact which explains the formation of reticulum in the latter and its absence in the former.

In his chapters on treatment, the author also stresses the danger of over-treating benign lesions with radiation, since this may cause the occurrence of malignant bone lesions.

In general, this book is considered indispensible in the diagnosis of bone lesions. It is one of the few devoted to this subject and one of the best at the same time.—Leo Lowbeer, M.D.

THE SCALP IN HEALTH AND DISEASE. Howard T. Behrman, M.D., Ass't. Clin. Dermatologist, N.Y.U. Postgraduate Medical School. $12.50. Pp. 566. 312 illustrations. The C. V. Mosby Co., St. Louis, 1952.

The first chapter, covering 115 pages of this book, deals with the embryology, anatomy and physiology of the scalp and hair in much detail and includes material on the microscopic structure and tensile strength of hair not found in most textbooks on dermatology. Following this is a chapter on the normal scalp, with a discussion of the preparations used on the hair, such as shampoos, lacquers, wave lotions and hair dyes. The third chapter, dealing with the various types of alopecia, probably consumes more space than the amount of definite knowledge on this subject justifies—a statement that applies also to the chapter on "The Seborrheic Diatheses" and to the one on "Disorders of Psychogenic Origin," which extends over 48 pages. So little is known about these subjects that much of the matter dealing with them seems redundant. On the other hand, in his effort to include in the book all diseases that at any time affect the scalp, the author has used a great deal of space for little more than a short description of these diseases—a treatment too brief to be of much value to one looking for real information on the subject. The scalp, being part of the cutaneous integument, is subject in some measure to most of the diseases that affect the skin and a work that attempts to cover all these conditions in detail goes a litt'e afield for a book about the scalp. For that reason it might have been as well if the author had limited this part of the work to those conditions peculiar to the scalp and those requiring special consideration from a treatment standpoint.

Although the book might be improved by abridgement in certain areas, several features, viz., the detailed exposition of the diagnosis and treatment of tinea capitis, the chapter on scalp and hair preparations, with appended formulary and the rather extensive bibliography are good and could be useful to dermatologists and others interested in the care of the scalp and hair.—Marque O. Nelson, M.D.

MICROPHTHALMOS AND ANOPHTRALMOS WITH OR WITHOUT COINCIDENT OLIGOPHRENIA. A Clinical and Genetic-Statistical Study. By Torsten Sjorgren and Tage Larsson. Ejnar Munksgaard, Norregade 6—Copenhagen 1949.

This monograph is a clinical and gentic study of two forms of blindness with particular attention to their association with feeble mindedness. The case material consists of 51 patients who had blindness associated with feeble mindedness and 79 in which feeble mindedness was not present. All the patients are inhabitants of Sweden where compulsory registration of such disease conditions has made possible an exhaustive statistical and genetical evaluation of these problems. Thus, the material can be considered to comprise "a complete iuventory of these diseases" in Sweden. Because of the nature of the subject matter, the monograph will have its interest limited to ophthalmologists and geneticists. The data suggest that microphthalmos and anophthalmos with or without congenital feeble mindedness is partially sex linked as a recessive trait with a reduced degree of manifestation. The eye defects when combined with feeble mindedness are also associated with some other congenital anomaly in 70 per cent of the cases. Epilepsy is an associated finding in 28 per cent of the cases. The life expectancy of the patient with combined blindness and feeble mindedness is short.—R. M. Bird, M.D.

TEXTBOOK OF PHYSIOLOGY. Eleventh Edition. William D. Zoethout, Ph.D. and W. W. Tuttle, Ph.D. The C. V. Mosby Company. St. Louis, 1952.

The preface to the second edition indicates that this book is intended to meet the needs of "the student in dental, pharmacy and normal schools" who has a limited time to devote to physiology. That the textbook is now in its eleventh edition is good evidence that it meets this demand. The very nature of the aims of the authors give the text obvious defects. Much of the material is presented in such an elementary fashion as to suggest that the reader has only the barest knowledge of biology and chemistry. On the other hand, the hurried handling of such complicated subjects as hormonal regulation and carbohydrate metabolism must leave such a reader rather confused. As a whole, it can be said that this is not a textbook of physiology which will attract the attention of either the undergraduate or graduate student in medicine. It will give to those who read it an exposure to the subject matter but it will hardly serve as a firm foundation for the interpretation of the pathological physiology of disease.—R. M. Bird, M.D.

OPHTHALMIC PATHOLOGY. An Atlas and Textbook. Jonas S. Friedenwall et al. W. B. Saunders Co., Philadelphia and London. 1952.

Tis text and atlas on ophthalmic pathology is published under the joint sponsorship of the American Academy of Ophthalmology and Otolaryngology and the Armed Forces Institute of Pathology. It is an outgrowth of the earlier "Atlas of Ophthalmic Pathology" by DeCoursey and Ash which was based on material in the Registry of Ophthalmic Pathology. Now in the present volume a text based on Friedenwald's "Pathology of the Eye" has been added and in addition up to date physiologic data have been included. The purpose of this book is provide the factual requirements in histopathology for board certification, to furnish a source book for residents in training who have limited teaching and laboratory facilities, and to furnish a convenient source for the ophthalmologist interested in furthering his knowledge of ophthalmic pathology.

The ext is writen by a group or recognized authorities in this field. Topics covered include general anatomy, pathology, histology, and physiology of the eye; growth and aging, inflammations, injuries; diseases of specific parts of the eye; congenital and developmental analomies; prenatal and neonatal diseases; heredofamilial and degenerative diseases; and tumors. Beautifully reproduced photomicrographs appear at the end of each section and total over 950. Numbered text and general references appear at the conclusion of each chapter.

This is an authoritative and exhaustive source book for the student of ophthalmology and will prove of interest and value to many outside this field.—R. A. Schneider, M.D.

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THE JOURNAL
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EDITORIALS

THE MENTAL HEALTH LAW

The new law having to do with mental health provides a board composed of two physicians, one of whom must be a psychiatrist, one attorney, and four laymen. There was much discussion concerning the personnel of the board. It was argued that previously the physicians composing the board had to take the brunt and that the problem is of such a nature that laymen should be given a place on the board and should assume their share of the responsibility.

The Sanity Board is now made up of two physicians and one attorney. It is required that the two physicians must examine the patient at the same time and through immediate consultation, reach their decision and advise accordingly. There is also a provision which authorizes the attending physician to send a patient to the institution for observation. This is not a formal commitment but is considered desirable for observation and diagnosis. If the patient remains longer than 60 days, his case must be surveyed by the Sanity Board and legally be committed. It is to be hoped that the application blanks and printed instructions as to methods of procedure may soon be made available.

THE NEW NARCOTIC LAW

The Narcotic Law passed by the recently adjourned legislature, provides that there shall be an enforcement branch in the Attorney General's office. Also that there shall be an Enforcement Chief and there is a provision for two additional enforcement officers. There has long been a need for enforcement that strikes across county lines. This need has been met by the new law.

It is difficult to know how successful this plan may be, but at least it will serve as a testing period and provide guidance for the next legislature if the execution of the present law proves unsatisfactory. There is a great need for enforcement in a distressing situation.

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MEDICINE MELLOWS THE HEART

The humanizing influence of medicine is incalculable. Not only does it condition the hearts and minds of medical men but it penetrates the inner sanctuaries of the non-medical.

Those who doubt the latter should read "This Was Ford," by Malcolm Bingay in the June 10, 1953, *Daily Oklahoman.* He reports the story as told to him by Roy D. McClure, M. D., Chief of Surgery of the Ford Hospital.

"He had just finished operating when a flash came that Henry Ford had been seriously injured in an accident at Greenfield village.

"Assistants and nurses were piled into an ambulance, and a police escort was obtained to rush out to Dearborn. When the ambulance roared up to the designated spot, the old gentleman was found sitting on a park bench with a little girl on his knee.

" 'We were riding our bicycles,' Ford explained, 'and we collided turning that corner.'

" 'Where are you hurt?'

" 'Oh, I'm not hurt. It's the little girl who is hurt. I want to make sure that she is all right.'

"Examination revealed that she suffered no damage other than a skinned knee.

"When assured of this, Ford said: 'Well, I wanted you to come out anyway. Look at that birthmark on her cheek. She tells me the boys and girls in school tease her about it. Doctor McClure, you are famous for your plastic surgery. Can you take it off and not leave any scar?'

" 'I'll have to study it first at the hospital.'

" 'Well, then, let's get going.'

" 'But, Mr. Ford, I cannot operate under the law without her parent's permission.' "

Her parents were from Czechoslovakia and the father employed by Ford. The interesting story of successful plastic surgery leaving a beautiful countenance, exceptional scholastic accomplishment, culminating in European travel for the patient and her parents all engineered by a great industrialist constitutes a distinct tribute to medicine.

William Osler on some mission near Johns Hopkins Hospital encountered a sick mother and two children sitting on the curb. Upon inquiry he learned that they were looking for the outpatient department at the hospital. After directing the way he tore a page from his notebook and wrote as follows:

"Please do what you can for Mrs. Osler and the children." With the signed note in her hand and no doubt, a song in her heart, she pursued her way. This spirit must not pass. Its survival depends upon the members of the medical profession.

THE GROWING PROBLEM OF VETERAN MEDICAL CARE

The recipients of the A. M. A. Secretary's Letter and a recent communication from H. H. Shoulders, M. D. of Nashville, Tenn. know that there seems to be a controversy over the ever increasing demand for veteran medical care and particularly over the care of the "acute non-service-connected cases". There is always the possibility that good may come out of controversy. Opposing opinions and pointed arguments stimulate reason, initiate search for evidence, and often discover neglected or hidden facts which thrown in the hopper may favorably alter the mill run and help to bring logical and equable conclusions.

Though this controversy may be unwarranted and unfortunate, all thinking physicians will agree that grave concern about the mounting problem is justifiable. In World War I we had about 3,000,000 veterans; in World War II we had approximately 11,000,000. Since the beginning of the Korean action many have been added and now every male child is a potential veteran. There is no way to tell whether time will change the situation. The problem deserves universal consideration. The veteran who has fought his country's battles deserves the best his country can give. But in the last analysis, if he is a good American and a good soldier, he wants only what is just and he will accept nothing that robs him of self respect.

THE MEDICAL SCHOOL

Though the University of Oklahoma School of Medicine is relatively young, it is surprisingly mature. In the past few years its progress has been phenomenal. It has reached a stage of development seldom achieved in such short time. The usual measuring stick is inadequate. There is no way to estimate its present and potential values. To appreciate this statement, one has only to consider the school's increased capacity, the Research Institute, the new library building, additional hospital beds, the nurses home, the recently secured full time men in certain departments and other recent developments including the new Veterans Hospital with its plans for cooperation.

The promising present rests largely upon past achievements. From humble origins with modest appointments, a great medical school has evolved. Often it sailed rough seas and suffered the sickening effects of political and financial squalls. But with commendable courage and fortitude the school weathered the storms and salvaged durable material for the further evolution of the school.

Confidently, it may be asserted that much credit goes to the men who organized the school and carried the torch through the difficult years and bridged the chasm that stretched between anticipation and realization.

Many of these courageous and hard working champions of the school have passed to their reward but the eyes of their ghosts are upon us. No doubt they are wondering what those at the helm will do with the vantage point from which they project their future; how they will meet the challenge posed by the popular demand for more and better physicians who are willing to enter general practice in the service of the people.

Those responsible for the school's policies should seriously contemplate the meaning of the public demand and its implications pro and con.

The school's response to this recognized need may largely determine its future. Either locally or nationally the people pay, and it is reasonable to believe that ultimately they will have their way. The medical school must continue to merit their support.

It is reasonable to believe that policies may have to undergo gradual changes. There is little danger of unreasonable demands from the people if they are properly informed. Through adequate popular education, well planned public health service and good private medical care, they will exercise enlightened judgment and follow professional leadership.

The Medical School should ever stand as the public's most treasured possession and command the continued respect and support of the people.

Scientific Articles

VARICOSE VEINS IN THE LOWER EXTREMITIES

A REVIEW OF THIS CONDITION[1]

JOHN POWERS WOLFF, M.D.

OKLAHOMA CITY, OKLA.

Varicose veins in the lower extremities are the varicosities that give us the most concern.

We divide our cases into two main groups. First, the patient who has a normal deep circulation. He may have simple varicosities with dependent edema with no ulcer or associated vascular spasm. There may be varicosities with simple ulcer, or varicosities with ulcer and severe vascular spasm.

Second, there is the patient who has had a deep phlebitis. He may develop any or all of the complications that the patient without phlebitis develops and in addition, incompetent valves in his deep venous drainage system.

Examination of the Patient

Every patient should, and does, have a complete physical examination. By this method, during each year we usually pick up several cases with other conditions that are endangering the patient's life and that demanded attention before the treatment of the varicosities.

Examination of the Legs

This consists of careful examination and evaluation of the arterial circulation and/or any other disease of the leg. We are particularly careful to note any evidence of former injury to the soft parts or the bone, any fungus infection, and the condition of the longitudinal and transverse arches in the feet. The condition of the toenails is often informative. A patient who has pain from other conditions in his feet will certainly not obtain relief from correction of varicosities.

The patient is examined in both the standing and prone position. A careful note is made of the position of all the varicosities.

The condition of the deep circulation is evaluated. Any skin change, ranging from a mild bronzing to severe ulceration, is noted. Surface temperature of the feet is observed and evidence of vascular spasm is noted by diminished pulsations, a wet cold foot and a delay of filling time in the foot. We consider a filling time of over 15 seconds abnormal. The normal young individual's veins fill much faster.

The presence or absence of valves throughout the great saphenous, is determined by the Trendelenberg test. This consists of having the patient lie on his back, elevating the extremity until the veins are empty, making point pressure over the saphenofemoral junction with the examining hand, and letting the patient stand. If the veins remain collapsed for 20 to 30 seconds, we feel that there are no incompetent communicating veins. If, upon release of the pressure, there is a quick reflux of blood throughout the length of the vein, from the saphenofemoral junction to the ankle, then we feel there is a complete absence of com-

petent valves throughout the length of the vein. One can use the high tourniquet instead of the test as originally described.

If the test has indicated that there are incompetent communicating vessels, then there are several tests that can determine the exact location of such vessels.

The multiple tourniquet test, as described by Doctors Oschner and Mahorner[2] or the bandage test, can be performed. The leg and thigh are bandaged in an esmark bandage and the bandage is gradually unrolled from above downward, with a tourniquet above. A communicating vessel will be obvious by a sudden bulge at that site. This can be marked, a tourniquet applied below the point, and the test continued downward. This test is useful as a combination of the bandage and tourniquet test.

After we have examined the patient, then we have to outline the necessary treatment.

The Patient with Simple Varicosities

This patient demands a careful eradication of all the superficial varicosities. At the present time, we are doing a careful high ligation of the long saphenous, being most careful to secure all the tributaries. This includes the pudendal vein, which often empties into the medical aspect of the femoral vein at the site of the saphenofemoral junction, and all of the usual and anomalous tributaries which may be present at this point. This procedure must be carried out in a dry field and all tributaries meticulously located and eradicated. We always transfix and ligate the terminal saphenous vein to prevent the possibility of secondary hemorrhage. If there is any doubt as to the anatomy involved, the femoral vein must be carefully identified before ligating the saphenous vein.

We obtained adequate exposure with a transverse skin incision and a vertical incision of the intermediate fascia. The intermediate fascia is carefully closed after closing the foramen ovale. In certain per cent of the cases, the external pudendal artery will be found passing superficial to the saphenous vein. These are the cases that frequently come into our hands with a recurrence, because it seems to be the general impression that this artery has a constant location between the femoral and saphenous vein. We find this occasional variation.

For a number of years, we did retrograde injections with sclerosing solutions.[1] Now we strip out the great saphenous vein its entire length with an intraluminal stripper. We usually pass the stripper from just above the internal malleolus proximally to the saphenofemoral junction after doing the high ligation. Sometimes additional incisions are necessary to pass the stripper the full length of the vein.

We have used several different kinds of strippers and do not think it makes a lot of difference which kind is used. At the present time we are using the strippers devised by Doctor Linten[4] of Boston.

It must be remembered that the great saphenous vein may be reduplicated. Then, at times there are perforating vessels, usually occurring in the lower half of the leg, that may involve tributaries of the great or lesser saphenous.[3] To care for these, we make an incision down to the deep fascia, lateral to the point of the vessel, approach the communicator from a lateral position, just superficial to the deep fascia, and divide and ligate it at the point where it passes through the deep fascia. If the perforator is large, then the defect in the fascia will be quite large. We repair this defect at the same time, as a small opening in the deep fascia will cause pain. We first realized that small defects in the fascia do cause pain, while caring for perforating wounds incurred in combat in World War II.

One can think of the short saphenous vein, which empties into the popliteal vein, as a low communicating and perforating vein, as it anastomoses with the long saphenous, both above and below the popliteal space. This vein can be ligated and stripped out if it is dilated and has incompetent valves. We usually approach this through a transverse incision in the popliteal space and pass our intraluminal stripper from that point, distally. We are aware that some prefer to make a vertical incision over this site and expose the vein at the junction with the popliteal vein; but this enlarges the operation with increased danger of nerve injury. In our hands, the simple procedure has been adequate with better cosmetic results.

There is one precaution that must be observed. The sural nerve is adherent to the short saphenous vein just below the popliteal space and, being a highly specialized sensory nerve, any injury to this nerve should be avoided. If one inadvertently places a suture about this nerve when closing the fascia, it may be necessary to crush the nerve before the patient obtains any rest.

On stripping out both the long and the short saphenous veins, we occasionally cause anesthesia of a small segment of skin either on the lateral or medial aspect of the leg. This causes little concern, but we warn our patients of this possibility preoperatively.

The Patient with Varicosities and Ulcer

If possible, we treat these people with pressure bandages preoperatively until any small ulcer has healed, in order to prevent infection in our wounds. We only occasionally operate them before the ulcer has completely healed. When we do, we risk infection in our incisions.

In cases with recurrent ulcers and encircling scar tissue or unhealed ulcer, we resect the ulcer down to the deep fascia, preferable to the muscle, and apply a split graft to the defect after the varicosities have been eradicated.

The Patient with Ulcer and Associated Persistent Vascular Spasm

The occasional case with a cold, wet foot and severe associated vascular spasm may require a lumbar sympathectomy before we can secure a healthy graft that will survive. These cases require careful supporting bandages to insure survival of the split graft on the leg. We advise the patient that if he is on his feet any great length of time, he may have to wear support on his leg the rest of his life to insure survival of the graft. A rest period during the day is advised. These patients are instructed to report to us at once if they have any break in the continuity of the graft.

Patients Who Have Had Deep Phlebitis

If they have simple superficial varicosities and edema, we advise that they merely wear a supporting bandage if they can be kept comfortable. Present care of patients with a phlebitis will usually prevent future surgery, though they may have to wear support on the leg the rest of their lives. Many of these patients require no support under care now given.

If the varicosities are unsightly, as may be expected when thrombo-phlebitis is neglected, we may operate the varicosities in order that the patient may wear a light nylon stocking and have a presentable leg. There is some difference of opinion as to whether this procedure is advisable. We feel that the patient should be allowed to choose.

If they have superficial varicosities, incompetent deep veins, and have developed an ulcer, they can be treated with ligation and stripping of the superficial varicosities, resection and grafting of the ulcer, and a sympathectomy if associated persistent vascular spasm is present. The patient is advised before the treatment that he will have a constant problem and will have to continue to wear an elastic bandage or stocking.

Phophylaxia and Aftercare

We use prophylactic antibiotics in all our cases. These antibiotics have made stripping a safe procedure in our hands.[1] We are more concervative in cases that have contra-indications; as advanced age, cardiac complications, or other contra-indications. We follow our cases in our office or in the outpatient department for several months and then advise that they should report once a year for a recheck as other varicosities may develop.

At one time, we treated our patients postoperatively with injection treatment of sclerosing substances We have learned that usually adequate surgery is sufficient. We much prefer to do additional minor ligations as an office procedure.

Anesthesia

We operate all our patients under light general anesthesia. We feel that spinal anesthesia is contra-indicated, as we do not want to lose muscle tone during the procedure or imediately following. Our anesthesiologists use endotracheal anesthesia, as they feel this is much safer when we turn the patient on his face to care for the varicosities in the popliteal space. This is necessary in a high percentage of cases.

We find that careful study of each case before operation enables us to give adequate surgery, which seldom leaves residual varicosities.

Summary

1. This discussion concerns varicosities and complications in the lower extremities.
2. Treatment is considered in two general groups:
   A. Those who have not had disease of deep circulation
   B. Those who have had phlebitis
3. Complete surgery and avoidance of sclerosing solutions is advised.
4. Types of anesthesia are discussed.

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THE USE OF ANTICOAGULANTS IN CORONARY ARTERY DISEASE

CAMP S. HUNTINGTON, M.D.
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The purpose of this paper is to review briefly the practical aspects of anticoagulant therapy in coronary artery disease as it is generally recognized today.

With proper indications for anticoagulants and precautions in their use coupled with the work of an able technician there is then no reason why the use of such drugs should necessarily be confined to cardiologists or internists. Proper training and much practice are necessary for the technician to produce reliable prothrombin times, which are absolutely essential in control of dicumarol or Tromexan dosage.

It is incumbent upon the doctors in the smaller communities to evaluate their available laboratory facilities and see that technicians become proficient in performing prothrombin times. If these are already being done and accepted at face value, the exact procedure and method of reporting should be carefully investigated by a member of the laboratory committee who has taken the trouble to thoroughly familiarize himself with the proper performance of this test. All too often in smaller towns the turn-over of laboratory technicians is frequent, resulting in inferior work which in the case of prothrombin times can be disastrous. Preferably the same technician should always perform the prothrombin time so that results are comparable.

In the absence of such understanding and control, the coumarin durgs are too dangerous to use.

INDICATIONS:

Generally, the indications can be divided into two large groups:

I. Use in the so-called "pre-infarction syndrome." [1]

II. Treatment after infarction has occurred.

In the first group are those patients with or without a history of previous coronary artery disease who devleop symptoms suggestive of impending infarction. In the case of the patient with a previous history of coronary disease with or without an old myocardial infarction, short bouts of anginal pain may begin at rest whereas for years it has always been produced by a given amount of exercise, or he may complain that for the last two or three nights he has been awakened by rather severe substernal pain that passed in a few minutes. An electrocardiogram may reveal recent changes in the ST segments or T waves without actual new infarction. This man is a candidate for hospitalization and immediate anticoagulant therapy until he stabilizes. In such a case, the use of an anticoagulant may be for 10 days or so to several weeks or more.

The same type of symptomatology may be seen in the patient who has never had any previous episodes. Here again the judicious use of anticoagulants may abort or lessen the extent of an actual infarction of the myocardium. The initial treatment of these patients is best carried out in the hospital and, subsequently, anticoagulant therapy with one of the coumarin products may be continued on an ambulatory basis if circumstances warrant it.

With respect to the use of anticoagulants in patients who have sustained an acute myocardial infarction, I doubt that any one questions their usefulness in lowering morbidity and mortality. There has developed, however, in the last year or two a more critical attitude in that much evidence has been produced to suggest that proper selection of infarction cases for anticoagulant therapy will give as good results as its routine use in every case, which exposes an unnecessary number of patients to the inherent danger of hemorrhage from anticoagulants. Even in skilled hands, hemorrhage

*Presented before the General Session at the Oklahoma State Medical Association April 15, 1953.

FIGURE I

HEPARIN TOLERANCE TEST AND TREATMENT SCHEDULE

According to Robert S. McCleery, M.D. and John A. Yarborough, M.D. "Circulation", Sept. 1951

(1) Base line coagulation time

(2) 50 mg. Sodium heparin I. V.

(3) 20 minutes later do coagulation time

(4) If coagulation time is — Give

<1 hr.	500 mg.	Depo-heparin or heparin-Pitkin's menstruum deep subcutaneously
1 hr. - 2 hrs.	400 mg.	
2 hrs. - 3 hrs.	300 mg.	
>3 hrs.	200 mg.	

(5) 20 hours later do coagulation time:

If coagulation time is	200 or 300 mg. groups min.	400 or 500 mg. groups min.	
well over			Wait 16 hrs.—Repeat same dosage
around	45	60	Wait 10 hrs.—Repeat same dosage
well below			Wait 4 hrs.—Repeat same dosage
around	25	25	Re-inject immediately

(6) Repeat regimen (5) as long as therapy is indicated.

has been reported as high as ten per cent with as many as one-two deaths per 100 cases reported by reliable investigators.[2]

In general, there is much to indicate that the so-called "uncomplicated" case of infarction does just as well without anticoagulant therapy provided simple leg and breathing exercises are carried out in the bed. This consists of deep breathing several times each hour and active motion of the toes, ankle, knee, and hip joints several times every hour or two. I have never seen any harm come from this in uncomplicated cases.

Although it is recognized that many authorities use anticoagulants routinely in every case of myocardial infarction, the growing conservative attitude toward use of anticoagulants in myocardial infarction is indicated by Russek's survey[3] in which slightly over one half of 228 specialists questioned did not employ anticoagulants routinely. A cross-section of opinion would suggest that the following are indications for anticoagulant therapy with the understanding, of course, that there are no physical contradictions such as severe renal or hepatic disease and that adequate laboratory control is available.

(1) Previous infarction
(2) Large infarction
(3) Cardiac enlargement
(4) Shock or other circulatory failure
(5) Previous thrombo-embolic phenomena
(6) Diabetes
(7) Severe debility
(8) Arrhythmia
(9) Protracted severe pain

At present there are two main types of anticoagulants used, heparin and the coumarin group of drugs of which dicumarol and Tromexan are members.

Heparin, a liver extract, inactivates thrombin and prolongs coagulation time. The action of sodium heparin by vein is immediate. Heparin is also given in repository form intramuscularly. For immediate effect, heparin is used and may be followed with one of the coumarin drugs. Heparin is controlled by use of the 3-tube Lee-White coagulation time. For effectiveness, the coagulation time should not fall below two times normal.

In case of heparin overdosage, the antidote is two per cent protamine sulfate in-

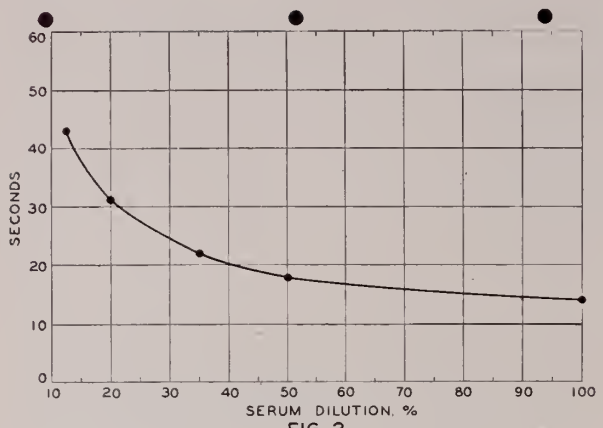


FIG. 2
PROTHROMBIN ACTIVITY IN NORMAL SERUM

travenously milligram for milligram, with or without whole blood as indicated.

If desired, sodium heparin may be given every four-six hours intravenously in doses of 50 to 100 mg checking the coagulation time until proper schedule is determined. If heparin is to be used, I believe one of the most satisfactory methods is that of Yarborough and McCleery in which the dosage of repository heparin is determined by a tolerance test.[4] The coagulation time is determined by a modification of Lowe's method. *Figure I*

When feasible, dicumarol or Tromexan should be started along with heparin so that the expense and inconvenience of the latter may be discontinued as soon as the prothrombin time has been sufficiently prolonged. The coumarin drugs are thought to act by preventing the synthesis of prothrombin in the liver. Their proper dosage is controlled by measuring the prothrombin time of the patient and a normal control to Quick's method. To be effective, the patient's time should be two to two and a half time of the patient and a normal control according to Quick's method. To be effective, the patient's time should be two to two and a half times normal in **seconds**, or more properly it should be measured in terms of percentage of normal prothrombin activity. Measured this way, an effective level would be between 10 and 30 per cent of normal activity. Laboratories should report control time in seconds, patient's time in seconds, and per cent of normal prothrombin activity. Any technician doing prothrombin times and any doctor using coumarin drugs should know how to construct this simple curve for measuring percentage of normal prothrombin activity. *Figure II.* Prothrombin times are run on three tubes of undiluted plasma from the same control and the average plotted as 100 per cent. All three readings should fall within one or two seconds of each other and usually run 12-15 seconds. The same procedure is done for plasma diluted to 50 per cent-35 per cent, 20 per cent, and 12½ per cent. It is particularly important that the technician be able to duplicate results within a second or two in 35 per cent, 20 per cent, and 12½ per cent plasma. The longer the prothrombin time the more difficult it is to read the end point. Once a satisfactory control curve is plotted, the patient's time in seconds may be interpolated on it to be the patient's per cent of normal prothrombin activity. A control curve may be used indefinitely provided it is checked from time to time when new batches of thromboplastin are used.

Dicumarol is usually given in 200 or 300 mg. initial dose and 100 mg. daily until effective levels are reached. Maintenance dose may vary widely. Once a consistent response is obtained to a given dosage schedule, a patient may go several days without a prothrombin time but certainly never over a week. I personally prefer to check more often than weekly even after the response seems consistent.

The physiologic antidote for coumarin drugs is vitamin K-1, an emulsion put out by Merck Company. It is given intravenously and usually 100 mg. is sufficient to control bleeding in three to four hours though its maximum effect is in one to two days. When indicated, whole blood is also used.

Tromexan is probably best used in divided doses, which vary from 1200-1800 mg./day. The onset of its effect and dissipation is more rapid than dicumarol. When given in single daily doses, the likelihood of hemorrage is greater than with divided doses.

When treating a case of myocardial infarction with any one of the anticoagulants, it is certainly desirable to continue them at an effective level until the patient is stabilized and ambulatory at least part of the time. In selected cases, amenable to accurate and close control, the physician may elect to continue one of the coumarin drugs indefinitely.

The value of periodic heparin as an adjunct in treatment of coronary disease has yet to be conclusively proved, though its use for direct relief of anginal pain does not seem warranted.

It has been shown that heparin reduces certain classes of lipoprotein molecules in

the plasma that are thought to be associated with atherosclerosis. When heparin is tried in such cases, it is usually given intravenously in doses of 50 to 100 mg daily several times a week for a week or two and then in 50-100 mg doses once a week, the hope being, of course, not to maintain an adequate prolongation of the coagulation time but rather that heparin will in time produce a shift in the lipoprotein metabolism toward normal. The final chapter in this form of therapy has not been written, many more carefully controlled studies being necessary.

CASE REPORTS: These two cases are offered not in an effort to represent that anticoagulants are infallible but rather to highlight practical problems.

CASE I: W. F. B. Age 48. This patient presented classical findings of severe coronary occlusion on January 4, 1952 while shovelling snow. He persisted in continuing to shovel even following onset of pain. He was brought to the hospital in shock, the blood pressure unobtainable. Oxygen, plasma, morphine, and atropine were given with improvement. The electrocardiogram was consistent with early posterior myocardial infarction. Heparin was started to maintain adequate prolongation of coagulation time, dicumarol not being used because of inadequate laboratory facilities at that time. After a stormy 48 hours, the convalescence was uneventful. Serial tracings showed gradual reversion of electrocardiogram to normal. Sedimentation rate, temperature, and WBC never indicated infarction of myocardium. Further evaluation showed that patient was moderately myxedematous having rather classical findings and a BMR of -43 and cholesterol over 400 mg per cent.

After stabilization, he was cautiously started on thyroid which was increased over a period of months to three grains per day. Clinically and by electrocardiogram, he seemed normal.

In July 1952, he had substernal pain awaken him on three successive nights, each a little worse, and after the last reported to the office. Electrocardiogram showed inversion of left precordial T waves without any QRS change. He was hospitalized, the thyroid stopped, and put on repository heparin for 10 days at the end of which time all findings were again normal. Following this, his only medication was a token dose of one half grain thyroid. Again he did well except for mild myxedma.

In November 1952, he had a third bout of substernal pain with T wave changes in the electrocardiogram. He was heparinized and also started on dicumarol. Again in about two weeks the electrocardiogram and physical findings were normal. Thyroid was again started and has been maintained at grains one and one-half per day. The dicumarol was discontinued on February 6, 1953 and since then the patient has been receiving periodic intravenous injection of 100 mg of heparin once a week. At present he is asymptomatic and leading a normal life.

Case II: M. H. M. Age 53. Painter. Came to hospital January 4, 1953 complaining of substernal oppression with aching in left arm. Onset two days ago. Aggravated by exercise. Electrocardiogram on January 5, 1953 showed inverted T_1, inverted TV_1—V_5 with depression of ST segments. He was treated conservatively with sedation, bed rest and Paveril phosphate, three grains every four hours. General physical was not remarkable and blood counts and sedimentation rates remained normal. Repeat electrocardiogram on January 7, 1953 showed improvement and tracing on January 9, 1953 showed further return toward normal. Clinically, the patient was negative and had only occasional complaints of left chest pain. On January 10 and January 11, 1953, pain in left chest and shoulder increased. Electrocardiogram on January 12, 1953 showed evidence of anteroseptal infarction with right bundle branch block. The temperature, sedimentation rate, and WBC rose, the temperature remaining as high as 103° for several days. He was started on heparin at once. The course was stormy, being complicated by congestive heart failure. On January 14, 1953, electrocardiogram showed what now appeared to be left bundle branch block. Clinical condition remained critical, oxygen, digitalis and heparin were continued. Electrocardiogram on January 15, 1953 showed anteroseptal myocardial infarction but disappearance of the bundle branch block. By January 23, the temperature had returned to normal and the patient made a slow but uneventful recovery, being discharged on the 26th of February for continued convalescence at home.

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President's Page

Elsewhere in this issue you will read a page advertisement announcing the procedure to be followed by members of the Association under the age of 65 who desire to enroll themselves and their families in Blue Cross.

This announcement is the culmination of a request by the House of Delegates for such action on the part of Blue Cross.

Your special attention is directed to the fact that if you do not enroll during this enrollment period, it will be necessary that you wait until the group is reopened sometime in 1954.

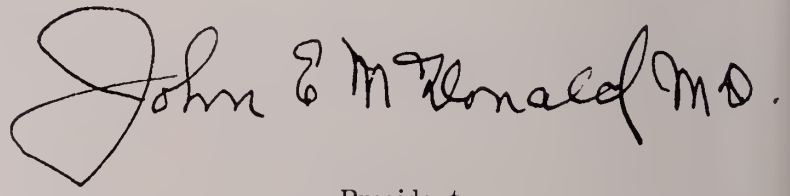
I personally hope each of you who do not have Blue Cross will seriously consider availing yourself of this coverage. Not only can it act in your behalf should you be out of the State and need hospitalization, but will materially assist your local hospitals who may have been giving you professional courtesy reductions in hospital costs for yourselves and your families which they are really not able to afford.

It is quite possible that during the enrollment period a representative of the Blue Cross plan will call at your office to discuss enrollment with you. Give him a welcome as he is a friend of yours there solely for the purpose of rendering a service to you.

If you are already enrolled in Blue Cross through another group, it obviously will not be necessary for you to re-enroll.

Every physician who is eligible should be a member of Blue Cross.

Several physicians have asked about the enrollment of their office personnel. This project is being considered at this time and it is hoped that a favorable announcement concerning the enrollment of the physicians' assistants can be announced in the near future.



President

Clinical Results* with Banthine® Bromide

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22 Published Reports Covering Treatment of 1443 Peptic Ulcer Patients with Banthine

Comprising the reports published in the literature to date which give specific facts and figures of the results of treatment

AUTHORS	No. of Patients	Chronic, Resistant to Other Therapy	TYPES OF ULCERS				RELIEF OF SYMPTOMS (Chiefly Pain)				Surgery or Complications[1]	Side Effects Requiring Discontinuance of Drug[2]	EVIDENCE OF HEALING			
			Duodenal	Jejunal	Stomal	Gastric	Good	Fair	Poor	No Report			Complete	Moderate	None	No Report
Grimson, Lyons, Reeves	100	100	93	7			80	11	4		5		47		19	29
Friedman	15	15	14			1	5		4	6[3]			2			13
Bechgaard, Nielsen, Bang, Gruetund, Tobiassen	26	26	21			5	16	4	6				8	6	12	
McHardy, Browne, Edwards, Marek, Ward	162		162				136	12	11		3	1	14	9	7	129
Segal, Friedman, Watson	34	34	34[4]				14	13			7	2	5		8	14
Brown, Collins	117	99	117				97	7	8		5	8	55	9	8	40
Asher	77		65		7	5	52	9	16			16		9	21	47
Rodriguez de la Vega, Reyes Diaz	5	4	5				4		1					3	2	
Winkelstein	116	116	102	8		6	102		14				53		18	45
Hall, Hornisher, Weeks	18	18	18				11		1	6[5]			18			
Maier, Meili	38	38	24			14[6]	27	7	4[7]				10	2	5	21
Meyer, Jarman	25	18	25				21		4							25
Poth, Fromm	37	37	37				33	3	1				33	3	1	
Plummer, Burke, Williams	41	41	41				36		5				38		3	
McOonough, O'Neil	104	100	104				63	10	31			11	4		11	89
Broders	60	60	58		1	1	35	19	6				10	1	49[8]	
Legerton, Texter, Ruffin	11		11				11									11
Holoubek, Holoubek, Langford	76	69	76				35	27	10		4	10	26		10	36
Ogborn	42		39	2		1	42[9]									42
Shaiken	48	48	48				33	10	3		2		33	10	3	
Johnston	145	145	145				143		2			2	143		2	
Rossett, Knox, Stephenson	146		141			5	146					4[10]	53			93
TOTALS	*1443*	*968*	*1380*	*17*	*8*	*38*	*1142*	*132*	*131*	*12*	*26*	*54*	*552*	*52*	*179*	*634*
PERCENTAGES		*67.8*	*95.6*	*1.2*	*0.6*	*2.6*	*81.3*	*9.4*	*9.3*			*3.7*	*70.5*	*6.6*	*22.9*	

1. Not included in tabulations.
2. Included in "Relief of Symptoms" as "Poor" and in "Evidence of Healing" as "None."
3. Four had no symptoms when Banthine therapy was begun.
4. Of which seven were penetrative lesions and five partially obstructive.
5. No symptoms were present in four.
6. Two with symptoms only; no demonstrable ulcer.
7. Three were psychopathic patients and one had a ventricular ulcer of the lesser curvature.
8. Roentgen findings after treatment period of two weeks; forty-seven had duodenal deformity.
9. All returned to work within a week.
10. In these four, after relief of symptoms, Banthine was discontinued because of urinary retention.

During the past three years, more than 250 references to Banthine therapy in peptic ulcer and other parasympathotonic conditions have appeared in medical literature. Of these reports, 22 have presented specific facts and figures on the results of treatment in a total of 1,443 peptic ulcer patients, 67.8 per cent of whom were reported as chronic or resistant to other therapy. These results are tabulated above and show:

"Good" relief of symptoms was obtained in 81.3 per cent of the 1,405 patients on whom reports were available.

"Complete" evidence of healing was obtained in 70.5 per cent of the 783 patients on whom reports were available.

In all but 9.3 per cent, relief of pain was "good" or "fair." In all but 22.9 per cent, evidence of healing was "complete" or "moderate."

During treatment, 26 patients required surgery or developed complications other than ulcer which required discontinuance of the drug before results could be evaluated.

Of the remaining 1,417 patients, only 3.7 per cent experienced side effects sufficiently annoying to require discontinuance of the drug.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

*Volume containing complete references, with abstracts of 39 additional reports, will be furnished on request by

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THE HISTORY OF MEDICINE IN OKLAHOMA

JAMES M. BABCOCK*

(Ed. Note) From month to month under the above title, the Journal will attempt to keep the plans and methods of procedure in the search for historical data before its readers and to print progress reports.

The department will publish some of the important evolutionary developments in our history as gleaned from biographical and other data now rapidly accumulating through the activities of your History of Medicine Committee through the Association officers and the Department of Archives at the University, also occasionally interesting episodes and anecdotes related to medicine. In other words, the purpose of this department is to focus interest upon the State Association's History of Medicine project and to spotlight some of the important events which ultimately may help to re-create a significant past. A past which eventually must take its place in the historical pageant of the medical profession in the general history of our country.

It is to be hoped that the folowing progress report will help to impress the importance of what is being accomplished and the need of a "brain dusting" and attic searching on the part of every member of the Association.

A month of intensive field work in several Southeastern Oklahoma Counties has resulted in the acquisition of 20 collections of medical records for preservation in the University of Oklahoma Archives. In search of these records, Jack Saunders, Archives representative, has interviewed almost 100 persons in Pittsburg, Latimer, Pontotoc, Coal and Atoka Counties. Pioneer physicians, their wives, their sons and daughters have been most cooperative in this joint project of the State Medical Association and the State University.

The scope of the collections thus far received is broad in point of time. In these papers may be found a record of medicine in the Indian Territory and the State of Oklahoma from the period of Reconstruction until the present day. This record is reflected in diaries, letters, photographs, certificates and diplomas and varied printed items.

Something of the story of the life of a naval surgeon, Dr. Alfred Griffith, for the Union forces who left civilized Baltimore for the Indian Territory is recorded in his own diary, which has been preserved by Mrs. Ethel Johnson of McAlester. A hint of the mysteries known only to the Indian medicine man is presented by an antique lance given to Doctor F. T. Barthold, a white physician of the Indian Territory.

*Acting Archivist, University of Oklahoma.

Each doctor carrying on individualy the practice of his profession found a need for association with his colleagues professionally and socially. These relationships are reflected in the records of the Pittsburg County Medical Association which are preserved through the generous cooperation of Doctor E. D. Greenberger and Doctor T. H. McCarley of McAlester. Groups of physicians were also associated for the purpose of providing more adequate clinical and hospital facilities as revealed by the records of the Albert Pike Hospital.

Among the papers presented to the University Archives by Doctor F. J. Baum, McAlester, is an account book of the nineties giving insight into the cost and nature of treatment, the types of affliction and other historically important information.

The photographic record of medicine in Oklahoma rapidly is being filled in by means of collections of significant photographs received. Notable examples are the Doctor T. S. Chapman Collection, given by Mrs. and Mrs. Walter Dell, McAlester; the Doctor T. T. Norris Collection, given by Mrs. Norris; the Mr. E. B. Hamilton Collection, Wilburton; the Doctor W. E. Van Cleave Collection, presented by Mrs. Van Cleave, McAlester; the Doctor McClellan Wilson Collection from Mrs. Wilson, McAlester. Photographs are also included in the Dr. W. P. Lewallen Collection, preserved by the Lewallen family of Indianola.

Dr. L. C. Kuyrkendall, practicing physician of McAlester gave the earliest of his records for preservation in the University Archives, together with Doctor G. R. Booth, Wilburton, who presented the records of his pioneer practice. Mr. Charles L. Cook, Hartshorne, has preserved the records of his father. The Doctor D. M. Hailey Collection has been set up by Mrs. Little, McAlester, daughter of Doctor Hailey.

Archives reflecting medicine in Pontotoc and Coal Counties have been received from Doctors S. L. Burns and Wallace Byrd. Mrs. M. E. McBride, Ada, assisted in the acquisition of materials relating to pioneer medicine in Ada.

The Doctor J. J. Hipes Colection of significant medical archives was received from Mrs. J. J. Hipes.

In the coming months even greater results can be hoped for because of the fine spirit of cooperation on the part of Oklahoma's physicians and their families. Any person knowing of the whereabouts of important medical archives or possessing such material is cordially invited to make them available for preservation in the University Archives.

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OBITUARIES

CARL F. SIMPSON, M.D.

1900-1953

Carl F. Simpson, M.D., 53, prominent obstetrician and gynecologist of Tulsa, Oklahoma, died at his hame June 22, 1953. Death was attributed to a heart ailment.

A Tulsan since 1911, Doctor Simpson attended the University of Pennsylvania and in 1926 received his medical degree from the University of Louisville School of Medicine. He entered practice in Tulsa in 1928.

Doctor Simpson served five terms as secretary-treasurer of the Tulsa County Medical Society and was formerly Chief of Staff at St. John's Hospital of Tulsa. He was a member of Alpha Kappa Kappa medical fraternity.

Funeral services were held June 24 in Tulsa. The widow and two children survive.

J. G. EDWARDS, M.D.

1881-1953

James G. Edwards, M.D., died May 23, 1953, of a coronary occlusion while driving his car.

Doctor Edwards, who had practiced in Okmulgee since 1919, formerly practiced in Covington, Tenn., and Henryetta, Okla. He was born at Rock Hills, South Carolina and graduated in 1908 from the University of Tennessee Medical School. He did postgraduate work at Tulane University and Cook County Hospital, Chicago. He was a member of the First Presbyterian church.

Surviving are the widow of the home address, two daughters and a brother.

ALBERTA WEBB DUDLEY, M.D.

1900-1953

Alberta Webb Dudley, M.D., assistant medical director of the Oklahoma Defense Blood Center of the American Red Cross in Oklahoma City, died June 1 in an Oklahoma City hospital of cancer.

Doctor Dudley was born in Indianapolis, Indiana and came to Oklahoma as a child. She received her degree from the University of Oklahoma School of Medicine in 1942. She was in private practice in Oklahoma City for several years and at one time served on the staff of Central State Hospital at Norman.

She was active in a number of medical organizations and a member of the faculty of the Oklahoma University School of Medicine.

Survivors include her husband, two sons, four sisters, her mother and a brother.

PHILIP KLINE, M.D.

1891-1953

Philip Kline, M.D., Tulsa, died June 16 at his home in Tulsa of a heart ailment.

Doctor Kline was born February 2, 1891 in New York City and came to Tulsa in 1925. He was graduated from the University of Nebraska in 1919. He was a veteran of World War 1. Four brothers survive.

F. MAXEY COOPER, M.D.

1899-1953

F. Maxey Cooper, M.D., Oklahoma City opthalmologist, died unexpectedly June 15 in his offices.

Doctor Cooper was born in Ozark, Ark. and was graduated from the University of Illinois with a bachelor of arts degree in 1921. He attended the University of Arkansas and in 1925 received his medical degree there. He did postgraduate work at Tulane University from 1926 until 1927. In 1928 he moved to Ponca City, after practicing in Oklahoma City a short time, but returned to Oklahoma City in 1930.

Among medical organizations in which he was active, he was a past president of the Oklahoma City Clinical Society. He was a Mason, a member of the Westminister Presbyterian Church, Kiwanis Club and Men's Dinner Club.

He is survived by his wife, two daughters and his mother.

M. E. ROBBERSON, M.D.

1880-1953

M. E. Robberson, M.D., pioneer Wynnewood physician, died June 7. He had been paralyzed since May 28.

Doctor Robberson was born January 8, 1880 at Marysville, Texas. He attended Southwestern University and Baylor and received his degree in medicine from the University of Louisvile in 1905. He came to Wynnewood, Indian Territory, in July of 1905. He later practiced in Brady before returning to Wynewood in 1919.

His son, M. E. Robberson, Jr., M.D., become associated with him in 1936.

He was an honorary member of the O. S. M. A. and active in civic and medical organizations.

HARRY B. HALL, M.D.

1891-1953

Harry B. Hall, M.D., Boise City, died May 26 of a heart ailment after being stricken in his office five days previously.

Doctor Hall was born in Lynn Grove, Iowa, June 28, 1891. He attended the St. Louis College of Physicians and Surgeons, St. Louis, and was licensed to practice in Oklahoma in 1922. He started his practice in Cimarron County. He moved to Woodward county in 1925 and practiced there until 1935 when he returned to Boise City.

Survivors include the widow of the home, one son, two brothers, and a sister. Two grandchildren also survive.

HARPER E. WRIGHT, M.D.

1887-1953

Harper E. Wright, M.D., Oklahoma City, died May 30 in a Cuthbert, Georgia hospital. He was stricken with a heart attack three days earlier while en route to Atlanta, Georgia, to attend the 40th reunion of the 1913 class of Emory University.

Doctor Wright was born at Rome, Georgia, and entered practice at Grandfield, Okla., following his graduation from medical school in 1913. He came to Oklahoma City in 1929.

He was active in medical organizations and a member of the Capitol Hill, Oklahoma City, Chamber of Commerce, St. Luke's Methodist Church, a Mason, Shriner, and past president of the Capitol Hill Kiwanis Club.

RESOLUTION

WHEREAS, Oscar Clarence Newman, M.D., Preceptor from Shattuck, Oklahoma, having served on the faculty since June 1, 1950, gave of his best for the relief of suffering of others, and set an example which will long continue to influence and inspire us, died on March 14, 1953, and

WHEREAS, by the death of Doctor Newman, the Medical Profession, the State, the Faculty of the Oklahoma University School of Medicine, and those who have depended upon him for help and counsel have a great loss, and

WHEREAS, we, the members of the Faculty of the Oklahoma School of Medicine, feel a keen sense of loss, both personal and professional, in the passing of our fellow member and desire to convey to the world our appreciation of his devoted service.

THEREFORE, BE IT RESOLVED, that we express to his relatives our sincere sympathy and our desire to share their great loss, and

BE IT FURTHER RESOLVED, that a copy of these resolutions be sent to the relatives of Doctor Newman, a copy spread on the records of the faculty, and a copy sent to the JOURNAL OF THE OKLAHOMA STATE MEDICAL ASSOCIATION.

May 5, 1953

s/ Earl D. McBride, M.D.
Committee on Resolutions
University of Oklahoma
School of Medicine

RESOLUTION

WHEREAS, Alberta Webb Dudley, M.D., Instructor in Medicine, having served on the faculty since December 4, 1944, gave of her best for the relief of suffering of others, and set an example which will long continue to influence and inspire us, died on June 1, 1953, and

WHEREAS, By the death of Doctor Dudley, the Medical Profession, the State, the Faculty of the University of Oklahoma School of Medicine, and those who have depended upon her for help and counsel have a great loss, and

WHEREAS, We, the members of the Faculty of the Oklahoma School of Medicine, feel a keen sense of loss, both personal and professional, in the passing of our fellow member and desire to convey to the world our appreciation of her devoted service.

THEREFORE, BE IT RESOLVED, That we express to her relatives our sincere sympathy and our desire to share their great loss, and

BE IT FURTHER RESOLVED, That a copy of these resolutions be sent to the relatives of Doctor Dudley, a copy spread on the records of the faculty, and a copy set to the JOURNAL OF THE OKLAHOMA STATE MEDICAL ASSOCIATION.

June 4, 1953

s/ Earl D. McBride, M.D.
Committee on Resolutions
University of Oklahoma
School of Medicine

A BIG TIME-SAVER FOR EVERY DOCTOR



This handy booklet for new mothers was "built to doctors' orders". It contains blank forms for filling in your instructions and formulas.

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CONGRESS ENACTS NEW DOCTOR DRAFT LAW

Congress enacted Public Law 84, which was signed by the President on June 29, 1953, extending the Doctor Draft Law until July 1, 1955. Publication of the provisions of the new law were not available for the August Journal but a review of the new provisions as provided by the Council on National Emergency Medical Service of the American Medical Association is herewith reprinted. The measure, as finally passed by the Congress and as signed by the President, will:

(1) Extend the effective date of the "Doctor Draft Law" until July 1, 1955;

(2) Retain the maximum ages specified in existing law: Registration, age 50; Liability for induction, age 51;

(3) Continue in effect the four priorities established by existing law with the following amendments:

(a) All service performed since September 16, 1940 as an officer or as an enlisted man, with certain exceptions which will be outlined later, will be credited as service. At the present time doctors in priorities 1 and 2 only receive credit for service performed "subsequent" to deferment of participation in a Navy V-12 or Army Specialized Training Program during World War II;

(b) The length of service required to qualify for priority 4 for doctors who were deferred or educated at government expense during World War II is reduced from 21 to 17 months. As a result of this provision a substantial number of doctors will be reclassified from priority 2 to priority 4.

(c) Establish the following new periods of service for men recalled to active duty or inducted pursuant to the "Doctor Draft Law":

Previous Service	*New Period of Duty*
9 months or less	24 months
9 to 12 months	21 months
12 to 15 months	18 months
15 to 21 months	15 months

(d) Removes the liability for induction or recall to active duty, except in time of war or national emergency hereafter declared by Congress, for those men in priority 4 who have had 21 months or more of service since September 16, 1940.

(4) Define "active duty" and "active service" to include:

(a) Full-time duty in the active service of the United States since September 16, 1940 in the Army, Navy, Air Force, Marine Corps, Coast Guard or United States Public Health Service, including reserve components;

(b) Time spent during World War II in work of national importance by conscientious objectors;

(c) Service performed before September 2, 1945 in the Armed Forces of countries which were allies of the United States during World War II; and

(d) Service performed as a physician or dentist by United States citizens employed by the Panama Canal Health Department between September 16, 1940 and September 2, 1945.

(5) Exclude from consideration as "active duty" periods spent in a Navy V-12 or Army Specialized Training Program; in a military internship, residency or senior student program; in military service for the sole purpose of undergoing a physical examination or while engaged in active duty for training entered into after June 29, 1953;

(6) Authorize the appointment of medical officers in grades commensurate with their professional education, experience or ability. This section is intended to provide for uniform treatment with respect to the ranks of all doctors called to active duty irrespective of whether they had previous military service;

(7) Continue until July 1, 1955 the authority to provide the "Special Pay" of 100 per month for doctors in the Armed Forces. This section also extends the class of persons eligible for such pay to include veterinarians;

(8) Authorize the commissioning of non-citizens of the United States as officers in the Armed Forces;

(9) Terminate automatically, upon completion of 12 months or more of service subsequent to September 9, 1950, the reserve commissions of all physicians taken into service by operation of the "Doctor Draft Law". Upon completion of this same service medical reservists recalled to active duty will be given an opportunity to resign their commission. Such persons, whether registrants or reservists, shall not be liable thereafter for recall or reinduction except in time of war or national emergency hereafter declared by the Congress;

(10) Reenact the present provisions of law which permit the deferment of those individuals who are essential to the national health, safety and interest;

(11) Authorize the national, state and local medical advisory committees to the Selective Service System, in addition to their present authority, to make recommendations with reference to the deferment of (a) registrants engaged in residency training, (b) those serving on faculties of medical and certain other schools and (c) those engaged in essential laboratory and clinical research;

(12) Extend until July 1, 1955, the authority of the President to recall medical reservists to active duty involuntarily;

(13) Be retroactive in effect. Those men already in uniform who would have benefited from the new changes in the law will, upon filing an application, be eligible for release from service as soon as possible and in no event later than 90 days after the effective date of the Act (June 29, 1953).

In considering the over-all effect of the new law it should be noted that the major changes involve greater recognition of prior military service. The result is that a particular registrant, by being able to take advantage of the various new provisions, may either (a) become exempt from liability for service, (b) be placed in a priority less vulnerable to immediate call, (c) be sub-

ject to a reduced term of service, or (d) effect a severance of military status within 90 days upon application or after the completion of his period of service by being either discharged or permitted to resign.

NOT ALL A.M.A. RECOMMENDATIONS ACCEPTED

Many of the recommendations made by the American Medical Association in its testimony before the Armed Services Committees of the House of Representatives and the Senate were accepted. Those which were modified or rejected are:

(1) The Association recommended that the liability for registration and call-up of veteran physicians in priority 4, as well as the involuntary recall of medical reservists in this category, be terminated as of July 1, 1953.
The law, as enacted, excuses from further liability those registrants and reservists in priority 4 with 21 months or more of service since September 16, 1940. This amounts to substantial acceptance of the Association's recommendation since between 85 and 90 per cent o fthe physicians in priority 4 have 21 months or more of service.

(2) The Association recommended that the second period of duty be limited to 12 months for a registrant or a reservist who had 12 or more months of previous service.
The law, as enacted, establishes a staggered period of service (see item 3 (c) above).

(3) The Association recommended that all accrued or terminal leave as well as travel time be included in computing total active duty.
Such credit was not allowed. The Armed Services Committee of the House of Representatives indicated that the reduction from 21 to 17 months to qualify for priority 4 was intended to take care of inequities of this type.

(4) The Association recommended that the reserve commissions of doctors called into service by operation of the "Doctor Draft Law" should not be vacated automatically upon completion of required service. It was the belief of the Association that doctors should be given the option of retaining or resigning their commissions. It was further recommended that reserve officers in the Navy and Marine Corps with service in World War II be permitted to resign their commissions immediately if they wished to do so.
The recommendations of the Association in this regard were not accepted.

(5) The Association recommended that any extension of the "Doctor Draft Law" be limited to one year.
The law was extended for two years.

You will be interested to know that the Council on National Emergency Medical Service has authorized the preparation of a brief and simple brochure explaining the provisions of the new "Doctor Draft Law", as well as the pertinent administrative regulations of the Armed Forces and the Selective Service System. It is planned to circulate this booklet through state and county medical societies for the information and benefit of individual physicians. If there are any particular facets of this subject which you believe should be stressed, we would appreciate receiving your comments and suggestions.

Should any reader have any question concerning this new Draft Law, it is suggested that he communicate with F. Redding Hood, M.D., Chairman of the Oklahoma Voluntary Advisory Committee, 1227 Classen Drive, Oklahoma City.

PHYSICIANS WILL CONTINUE TO BE CALLED FOR MILITARY SERVICE

Notwithstanding the enactment of the new Doctor Draft Law, additional Oklahoma physicians will be called to military duty each month for an indefinite period of time.

Due to the lateness of the enactment of the new Doctor Draft Law, no Selective Service quotas were announced for July but will be included in the August call.

Oklahoma's allotment under these calls have ranged from three to five monthly although subsequent calls may be stepped up to meet the mid year lag.

The new law which allows physicians trained under the ASTP and V-12 programs to count active military service prior to their ASTP and V-12 training, but subsequent to September, 1940, will place certain Priority One and Two physicians in Priority Four, thus placing the Priority Three physician in a more vulnerable position for military service.

RELEASED FROM SERVICE

Physicians listed below have been reported to the Executive Office as being on active duty:

E. Stanley Berger (Capt.), formerly of Oklahoma City, reported July 8 and assigned to Puerto Rico.

Benjamin H. Brown (Lt.) USAF, reported May 23, formerly of Oklahoma City.

Richard M. Burke (Lt. Col.), Oklahoma City, reported to Fort Sam Houston, San Antonio.

Ellis Edwin Fair (Maj.), Oklahoma City, USAF, reported May 23.

C. F. Foster, Oklahoma City, reported in June.

Carl Krieger, Jr. (Lt.), Oklahoma City, USAF, reported May 23.

H. V. L. Sapper (Capt.), Oklahoma City, reported May 1 to Fort Knox, Kentucky.

ON ACTIVE DUTY

Oklahoma physicians recently released from service are:

W. P. Dickinson (Lt.), Formery of Tecumseh, now of Ardmore, was stationed in Germany.

Orin J. Hake (Lt.), Seminole—was stationed at Fort Sill and the Far East.

Hollis Eugene Hampton (Capt.) Antlers—stationed at Maxwell AFB, Montgomery, Alabama.

Robert L. Loy (Lt.), Oklahoma City—stationed at Fort Sill.

Jack B. McGolrick (Capt.) Clinton—stationed at Denver.

Robert J. Miller (Capt.) formerly of Bartlesville—stationed at Lackland AFB, San Antonio.

Robert F. Shriner (Capt.), Hobart—served in Japan, Korea and Fort Sill.

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DOCTOR CAMPBELL RECEIVES O.S.M.A. PIN

A former teacher turned doctor is H. G. Campbell, M. D., Tecumseh who recently received a 50 Year Pin.

Doctor Campbell, who is 80 years old and recently completed 50 years in the practice of medicine, received his A. B. degree in 1895 from an Arkansas college and taught school for four years before entering Nashville University Medical School where he graduated from medical school, he was highest in his class of 50. After interning at Nashville City Hospital, he entered practice at Newport, Ark. and came to Oklahoma three years later. Doctor Campbell practiced at Asher and Shawnee until he moved to Tecumseh 10 years ago.

Active in medical organizations, he is a former president of the Pottawatomie County Medical Society, and has also headed the Chamber of Commerce and Rotary Club. Last year he attended the Rotary International convention at Mexico City.

Doctor Campbell's 50 Year Pin was presented at a meeting of the Pottawatomie County Medical Society. Presentation was made by Clinton Gallaher, M. D., secretary of the society.



Doctor Gallaher pins a 50 Year Pin on the lapel of Doctor Campbell.

Announcements

OKLAHOMA STATE MEDICAL ASSOCIATION. Annual Meeting May 10-11-12, 1954. Oklahoma City.

AMERICAN MEDICAL ASSOCIATION. Interim Session, St. Louis, Mo., December 1-4.

SECOND INTERNATIONAL CONGRESS OF CARDIOLOGY. Washington, D. C., September 12-15, 1954.

SOUTHWESTERN SURGICAL CONGRESS. September 21-23, Salt Lake City, Utah.

UNIVERSITY OF COLORADO SCHOOL OF MEDICINE will sponsor a three day post graduate course in "Recent Advances in Infectious Diseases" August 17, 18, 19. For further information write to the Office of Graduate and Postgraduate Education, University of Colorado Medical Center 4200 East Ninth Avenue, Denver 20, Colo.

SOUTHERN MEDICAL ASSOCIATION. October 26-29, Atlanta, Georgia.

BLUE CROSS PHYSICIAN ENROLLMENT TO BE OCTOBER

All O. S. M. A. members not presently enrolled in Blue Cross will soon have an opportunity to do so.

As a project of the Association, plans are now under way to make the hospital service benefits of the Oklahoma Blue Cross Plan available to all state physicians and their family dependents.

Tentative dates for accepting applications have been set during the month of October. Payment of dues for this new group will be on annual basis with statements mailed direct from and payments made to the Blue Cross office in Tulsa. Other details have not been completed.

While approximately 15 county societies are now enrolled in Blue Cross groups, many physicians have previously not had an opportunity to enroll. Physicians now enrolled may continue in their present group.

Watch for further details which will be published in the September *Journal*.

Have You Heard?

J. C. Hallford, M.D., recent graduate of the University of Oklahoma School of Medicine, has taken over the practice of the late Harry B. Hall, M.D., of Boise City.

D. G. Divine, M.D., Wagoner, retired July 1 after 40 years of medical practice.

H. A. Angus, M.D., Lawton, attended the 50th anniversary reunion of his graduating class from the University of Iowa School of Medicine in June.

F. Redding Hood, M.D., Oklahoma City, has been named president of the Oklahoma State Heart Association.

David C. Clemans, M.D., 1952 graduate of the University of Oklahoma School of Medicine, is now practicing in Hartshorne.

Hugh Wesley Yeats, M.D., Sulphur, has recently completed his 50th year in the practice of medicine.

Stewart G. Wolf, M.D., of the University of Oklahoma School of Medicine was recently awarded a $1,500 psychiatric prize for his work in collaboration with Thomas H. Holmes, M.D. on a volume entitled, *The Nose*, published in 1950.

Lillian Hoke, M.D., formerly McCurtain County Health Officer, has accepted a residency at Central Maine General Hospital, Lewiston, Maine.

C. A. Traverse, M.D., Alva, has been elected president of the University of Oklahoma School of Medicine Alumni Assocaition.

Kieffer Davis, M.D., Bartlesville, has been named first vice-president of the Industrial Medicine Association.

John Highland, M.D., Miami, has been elected president of the Rotary Club of that city.

ERRATUM

In the June, 1953, issue of the Journal of the Oklahoma State Medical Association the word, "Psychiatrist," is used in three places instead of the word, "physiatrist," which should have been used. The article in which the errors appear is "The Management of Neurogenic Bladders from the Rehabilitation Standpoint," by John W. Deyton, M.D.

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THE 1952-53 ACTIVITIES OF THE OKLAHOMA CHAPTER OF THE STUDENT MEDICAL ASSOCIATION

LAWRENCE MCHENRY

The 1952-1953 officers of the Oklahoma Chapter of the Student American Medical Association were Tom Moore, third-year student from Cleveland, Oklahoma, President; Lawrence McHenry, second-year student from Oklahoma City, Vice-President; Jake Jones, third-year student from Shawnee, Oklahoma, Secretary; and Bob Stover, fourth-year student from Miami, Oklahoma, Treasurer. The advisors to our chapter were A. N. Taylor, Ph.D., Associate Dean; Garman Daron, Ph.D.; and Robert M. Bird, M.D. as Faculty Advisors; L. J. Moorman, M.D. represented the Oklahoma State Medical Association and Leo Cailey, M.D. represented the Oklahoma County Medical Society.

At the first of the year a dinner meeting of the officers and advisors was held. The coming program and activities of the chapter were discussed. Several fields of endeavor for our student organization were suggested but it was concluded that our main purpose should be to first demonstrate the virtues and necessities of organized medicine, and secondly, to enlighten and educate the students on the economic and social responsibility and relationship they must assume in the medical profession.

The program of the first meeting was a very informative talk by George Garrison, M.D., Chairman of the Grievance Committee of the Oklahoma State Medical Association. Doctor Garrison told of the purposes and activities of the Grievance Committee and how it serves to further the public relations of the medical profession in Oklahoma. John McDonald, M.D., then President-Elect of the State Association, gave a short address on the need for a better relationship with the public.

At the second meeting of the year, there was a panel discussion on the internship program. Members of the panel were Stewart Wolf, M.D., Professor of Medicine; Henry B. Strenge, M.D., Associate Professor of Pediatrics; James Pitts, M.D., Resident in Obstetrics and Gynecology; and John Carson, M.D. of Shawnee, Oklahoma. Robert M. Bird, M.D., Associate Professor of Medicine, acted as moderator. Since the internship is an integral part of the medical student's training, this introduction to it proved to be very enlightening. Each year with the new graduating class it seems as if there are many students who do not realize the purpose of an internship in their medical training. Our panel discussion attempted to ameliorate this situation.

Alfred R. Sugg, M.D., then President of the Oklahoma State Medical Association, was the highlight in an informal discussion at our third meeting. Doctor Sugg, in his illustrious manner, told us of the necessity for teaching the students the art of medical practice. He also emphasized the need for participation on the part of practicing physicians in the actual teaching program in the clinics and lecture rooms. The students thoroughly enjoyed this innovation.

The final meeting of the year was a symposium on the preceptorship program. William Finch, M.D. of Hobart, E. A. McGrew, M.D. of Beaver and Ray Lindsey, M.D. of Pauls Valley told the group how they introduced the preceptee to actual medical practice. The student, on the 11 week preceptorship, usually stays in the hospital of the local community; he sees the preceptor's patients; assists in surgery and obstetrics; and makes house calls with the doctor. A. N. Taylor, Ph.D., Associate Dean, moderated the program and told of the actual teaching value gained from the preceptorship and how Oklahoma was one of the first to adopt this program.

R. R. Robinson, third-year student from Enid, was Delegate to the annual convention of the House of Delegates which met during December, 1952. O. H. Patterson, second-year student from Ada, was the alternate delegate. There was apparently little accomplished at this meeting, most of the work being postponed until the meeting this June. The president and vice-president of the Oklahoma chapter were present at the Tulsa meeting of the Oklahoma State Medical Association.

At the final meeting of the year, officers for the next year were chosen and delegates to the June convention of the House of Delegates were appointed. Lawrence McHenry, second-year student from Oklahoma City, was elected President; Cecil Chamberlin, second-year student from Frederick, Vice-President; James Calhoon, first-year student from Beaver, Treasurer; and Guy Fuller, second-year student from Oklahoma City as Secretary.

In conclusion we wish to thank the Public Policy Committee for a grand Bar-B-Que dinner. It is through these more informal get-togethers that the students become better acquainted with each other and with the officers of the State Medical Asociation.

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AN ANNOUNCEMENT TO OKLAHOMA PHYSICIANS

The Oklahoma State Medical Association and the Blue Cross Plan take pleasure in announcing that in September all O.S.M.A. members will have an opportunity to enroll in the Oklahoma Blue Cross Plan. ☆ ☆ ☆

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CHECK THE SEPTEMBER JOURNAL FOR COMPLETE DETAILS ABOUT THIS ENROLLMENT!!!

Meet Our Contributors

Camp S. Huntington, M.D., Bartlesville, is the author of "Use of Anticoagulants in Coronary Artery Disease". Doctor Huntington, who was graduated from George Washington University School of Medicine, Washington, D. C., in 1939, specializes in industrial medicine. Doctor Huntington was in the service from 1941-1946 and was a major when released.

John Powers Wolff, M.D., Oklahoma City, wrote "Varicose Veins in the Lower Extremeties" which now appears in this issue. Doctor Wolff is a fellow of both the American and International College of Surgeons. His specialty is general and vascular surgery and he is a 1927 graduate of the University of Oklahoma School of Medicine. A World War II veteran, he saw 37 months service overseas and was a major when released from service.

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BOOK REVIEWS

NUTRITION AND DIET IN HEALTH AND DISEASE. James S. McLester, M.D., Professor of Medicine Emeritus, University of Alabama, and William J. Darby, M.D., Ph.D., Professor of Biochemistry and Director of the Division of Nutrition, Vanderbilt University. Sixth Edition, W. B. Saunders Co., Philadelphia and London, 1952. 700 pages.

This very complex text has been thoroughly revised and brought up to date by the authors. There is an introductory section dealing with the physiologic and biochemical bases upon which the subject rests, followed by a discussion of the roles of the vitamins and inorganic constitutents. Then follows a section on food products (milk and milk products; meat, fish and eggs: the grains: vegetables; fruits; etc.) which leads directly to the consideration of normal diets (for adults in pregnancy, in pediatrics, and in geriatrics).

The final section deals with "nutrition in disease" which is divided first into broad organ systems and then in to specific disease states. Each part is prefaced by a short discussion of the basic processes concerned in each disease state. These are weak, sketchy and seem somewhat out of place in a book of this sort. Where the book concerns itself with the problems of diet and nutrition it is very good, and the extensive use of charts and graphs is excellent. There is thorough discussion of the system of "dietary equivalent" as used in the preparation of diabetics diets.—John Colmore, M.D.

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Adult	2.50	5.00	7.50	10.00
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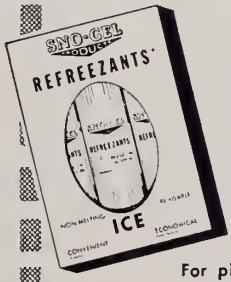
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CURRENT ACTIVITIES AT THE OKLAHOMA MEDICAL RESEARCH FOUNDATION

EDWARD C. REIFENSTEIN, JR. M.D.,
DIRECTOR



The Walter Reed Society and its role at the Oklahoma Medical Research Foundation form the basis of this, the 20th article in the series on Current Activities at the Foundation.

A brief description of the Walter Reed Society will serve to show its value aud purpose at the Foundation. The Society was officially organized in Los Angeles on December 7, 1951, under the auspices of the National Society for Medical Research as a non-profit educatioual and charitable association of volunteer human subjects for medical research. It is named for Major Walter Reed of the United States Army who risked his life in a series of brilliant Yellow Fever experiments, and who first dramatized the use of the human medical volunteer. In the medical sciences, the only method which can clearly reveal and establish the cause, prevention aud treatment of disease is the method of controlled experimentation on animals and volunteer human subjects.

There are indications in the oldest literatures of research studies on animals and on man, but the great importance of controlled experiments on both species for the benefits of both was not fully demonstrated until 1628. In that year, Harvey anounced his "discovery of the circulation" which involved observations on man and animals. Now, medical scientists, students and others serve, with great frequency, as subjects in medical experiments designed to advance human welfare. Such experiments are conducted according to well-established ethical principles in all countries of the world. Obviously medical experiments first must be performed on the lower animals to avoid random, harmful and unnecessary experimentation on man. The final test, however, mut be made on the human subjects . . . the "medical volunteer", who, by his service, advances medical knowledge.

The purposes of the Walter Reed Society are, briefly, to provide recognition for contributions to medical progress by the human medical volunteer; to provide for the exchange of scienitfic inforuation on medical experimentation involving human subjects so that clinical research may becoue increasingly efficient and safe to afford medical research volunteers with a continuing role in the war against disease; and to develop public understanding and support of medical research.

Any person who has participated as a volunteer subject under qualified scientific direction is eligible for membership. Applicants must present a statement from the scientist directing the investigation in which they participated. Membership in this organization includes eight classifications. These are: (1) Local Organization Members, or local orginazations of volunteer medical research subjects operating in accordance with the general policies of the Society; (2) State Organization Members, or organizations that quality on a state-wide level; (3) Associate Individual Members, or scientists engaged in research which involves human subjects, who contribute important data to scientific knowledge; (4) Associate Organization Members, composed of scientific, civic, professional and commercial organizations interested in matters of health and research; (5) Individual Members, who have participated as a volunteer subjects in a medical experiment under qualified scientific direction; (6) Fellows, or qualified medical investigators who have both conducted experiments on human subjects and served as experimental subjects; (7) Distinguished Service Members, or persons who have made outstanding contributions as volunteer medical research subjects; and (8) Distinguished Service Fellows, or scientists who have made outstanding contributions to medical knowledge involving some personal jeopardy as experimental subjects.

In July of 1952, it occurred to us that the establishment of a Chapter of the Walter Reed Society at the Oklahoma Medical Research Foundation and the election of the patient volunteers who served as subjects in the Research Hospital would place a "mark of distinction" on those individuals who having contributed personally to medical research and progress in Oklahoma. It is never possible to guarantee any patient who enters the Research Hospital as a subject for study that he will derive personal benefit from the investigation; but the sum total of human knowledge is advanced and this will benefit others. The stimulus of membership to the morale of the patient has been great, and has helped to spread an appreciation of the work of the Foundation throughout the State.

The Foundation Chapter was initiated in September, 1952, by several qualified scientists becoming members of the Society and then applying for permission to formulate the new chapter. Dr. Edward C. Reifenstein, Jr., was appointed Chairman of the Chapter, and this small group formed the nucleus which has grown since that time to include 22 individual members among the patients for whom the Chapter was created. One posthumous award of membership has been given.

When an aplication for membership is made in behalf of the patient and has been approved by the National Society, the patient receives a membership card, a certificate of membership which bears the seal of the organization and which is suitable for framing, and a brochure explaining the import of attaining membership of the Walter Reed Society. Thus the patient can realize the appreciation of others of his contribution to medical research, not only locally at his Foundation, but on a national and international level as well. The membership continues for the period of one year and can be renewed annually. The dues for the first year have been paid by the Foundation.

The Walter Reed Society as a national organization now has a membership of over one hundred members, with local chapters in Oklahoma City, California, and Illinois. Other chapters are being formed. As a means of furthering public relations in regard to medicine and to clinical investigation, the Society has a potential for an important role in benefiting doctors, scientists, and patients alike. Many of the original members of the Oklahoma Chapter have now been discharged from the Research Hospital, but they know that their volunteer service to mankind has been recognized on a local and national level, and they are justifiably proud to have been privileged to serve in the progress of science and of medicine.

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OFFICIAL PROCEEDINGS OF THE HOUSE OF DELEGATES

OF THE

OKLAHOMA STATE MEDICAL ASSOCIATION

APRIL 12, 1953

MINUTES OF THE CLOSING SESSION

The closing session of the 60th session of the House of Delegates of the Oklahoma State Medical Association was called to order by the Speaker in the Emerald Room of the Mayo Hotel, Tulsa, Oklahoma, April 12, 1953, at 7:30 P. M. The credentials committee stated that a quorum was present.

Doctor Gallaher announced that Lewis J. Moorman, M.D., Oklahoma City, wished to introduce a guest. Doctor Moorman introduced James Babcock, Archivist of the University of Oklahoma Library, who gave a brief talk on his work on the History of Medicine for the Association. Mr. Babcock expressed the appreciation of the University of Oklahoma for the grant of the Association for the collection of materials for the History of Medicine and asked for the cooperation of all doctors in the State in this endeavor.

The Speaker anounced a continuation of the Report of the Organization Committee. He asked Doctor McHenry to take the Chair and Doctor McHenry called for a discussion of the first item to be considered in the Report, which was to take some definite action in regard to the surplus funds. J. R. Colvert M.D., Oklahoma City, moved: ''That the surplus funds be invested in building and loans, presumably at three per cent interest.'' Motion seconded and carried.

Doctor McHenry asked for a discussion as to the contemplated expenditure for renovating of the files in the Executive Office. Shade Neely, M.D., moved that the House of Delegates instruct the President to appoint a permanent State Housing Committee to study this Problem. Alfred R. Sugg, M.D., seconded. Motion carried. J. R. Colvert, M.D., moved ''that we have a renovation of the files not to exceed a cost of $500.00''. Motion seconded and carried. Next was a discussion of the proposed salary increases. J. R. Colvert, M.D., moved ''That the raises be granted''. Motion seconded and carried.

The next item to be considered was the Retirement Pension Plan. Doctor McHenry explained the plan the Committee wished to submit.

After considerable discussion, Doctor Alfred R. Sugg advised the delegates that it was going to be necessary to leave the details of this up to the Committee which had been appointed for that purpose. Doctor M. O. Hart moved: ''That the recommendation of the Organization Committee relative to the Retirement Pension Plan be approved. Doctor John McDonald seconded and the motion carried.

The next item was to set the amount of dues for the coming year. Shade Neely, M.D., Muskogee, moved: ''That the recommendation of the Committee that the dues be set at $42.00, the same as previously, be adopted. Motion seconded and carried.

Folowing this was a report from the Resolutions Committee. J. D. Shipp, M.D., Tulsa, made the Report for this Committee. Doctor Shipp read the Resolutions which had been submitted to the Committee, action was taken on each one individually and the folowing Resolutions adopted:

RESOLUTION ON MENTAL HEALTH

WHEREAS, the State of Oklahoma and its people have a moral and legal obligation to our mentally ill citizens, and

WHEREAS, approximately eight thousand of such mentally ill citizens are confined in the mental Institutions of this State, and

WHEREAS, the Committee of the House of Representatives of the Twenty-Fourth Oklahoma Legislature now engaged in the investigation of the Mental Institutions of this State has received sworn testimony, which if substantiated would indicate a need of reorganization of administration, personnel, treatment and financing, and

WHEREAS, the medical profession is peculiarly equipped because of the training and experience of its members to assist in the solution of the problems of the Mental Institutions of this State, and

WHEREAS, the rehabilitation of patients of the Mental Health Institutions of the State, whose condition is such that they are amenable to rehabilitation would favorably affect the general economy of the State and of the Mental Health Institutions as well as of the patients and their families.

NOW THEREFORE, BE IT RESOLVED that the House of Delegates at this Sixtieth Annual Meeting of the Oklahoma State Medical Association expresses the complete willingness of the Association to cooperate with the Legislature in any further investigation, particularly in the field of medical care, which may be indicated, and

BE IT FURTHER RESOLVED that the Oklahoma State Medical Association stands ready to make available a Committee of the Association to conduct or assist in the conduct of such further investigation as to care and treatment as may appear desirable to the Legislature or the Department of Mental Health.

RESOLUTION

WHEREAS, members of the Oklahoma State Medical Association realize that ill-advised, unfounded, false, misleading and vitriolic news releases or statements—such as were recently made in the lay press by Paul R. Hawley, M.D., Executive Director of the American College of Surgeons, and endorsed by the governing board of the American College of Surgeons—have done infinitely more harm to an understanding between doctors of medicine and the American public than can be corrected by years of patient, thoughtful and well considered effort, and

WHEREAS, the Oklahoma State Medical Association steadfastly and sincerely believes in the basic honor, both personal and professional, of the medical doctors of the United States, and

WHEREAS, the Oklahoma State Medical Association believes the task of solving this situation can only be accomplished by and through the American Medical Association,

NOW THEREFORE BE IT RESOLVED, that the American Medical Association be asked to immediately

contact the American College of Surgeons, or any other medical organization, to prevent the recurrence of such statements by any official representatives of the American College of Surgeons or any other medical organization that are unethical and tend to destroy the confidence of the public at large in all physicians, and

BE IT FURTHER RESOLVED, that the Oklahoma State Medical Association invites the American College of Surgeons to submit to it any documentary evidence it has concerning the unethical practices of any physician who is a member of the Oklahoma State Medical Association, and

BE IT FURTHER RESOLVED that the American Medical Association be asked to continue to resist attempts by any group, or spokesman for any group, to impugn the judgment of any qualified doctor of medicine, in performing any services for which he is qualified, and

BE IT FURTHER RESOLVED that a copy of this Resolution be forwarded to the American Medical Association and the American College of Surgeons.

Resolution to Standardize, Shorten, and Simplify Medical and Hospital Insurance Plan Forms

WHEREAS, there has been a phenomenal increase in the number of insurance companies writing, selling and servicing hospitals, medical, sick and accident insurance plans, and

WHEREAS, there is no uniformity in the forms to be executed and some are of unreasonable length, and

WHEREAS, the medical profession is desirous of cooperation to the fullest, but is finding the cooperation difficult and expensive,

NOW THEREFORE BE IT RESOLVED, that a committee of the Oklahoma State Medical Association, be appointed to examine or consult with, or aid the insurance companies in the preparation, and endorsement of a uniform blank to be used by companies writing such coverage in the State of Oklahoma, and that this Committee report its progress at each meeting of the Council until a satisfactory and acceptable form is completed, the first report to be not less than six months from the date of this meeting at the House of Delegates.

RESOLUTION
PUBLIC HEALTH

WHEREAS, various groups and individuals come to the State Health Department and its component units expecting service, outside of the field of Preventive Medicine,

NOW THEREFORE BE IT RESOLVED that the Oklahoma State Medical Association go on record as requesting the State Health Department to continue to restrict its activities to the field of Preventive Medicine. It is specifically held that it should not assume the responsibility for the medical or nursing care of sick individuals except on orders of a practicing physician.

Resolution on Non-Service Connected Disabilities

WHEREAS, the furnishing of hospital care, professional services, drugs, and appliances to war veterans for non-service connected disabilities is discriminatory, and no more justifiable than would be the furnishing to them of legal services, automobiles, food, clothing, and housing at public expense, and

WHEREAS, there is no more moral justification for furnishing these services for non-service connected disabilities at the expense of the general, tax-paying public than there would be for furnishing such services to any other special class of persons in our society, and

WHEREAS, the hospitalization and treatment of veterans for non-service conected disabilities is unnecessary, undemocratic and a mere subterfuge for the maintenance of a huge bureau offering patronage and employment on a political favoritism basis to carry out a non-governmental function, and

WHEREAS, the abolition of veterans administration facilities for non-service connected disabilities would permit more efficient care of those veterans with service connected disabilities, which is an unchallenged debt of society to its wounded and injured war veterans,

NOW THEREFORE BE IT RESOLVED that the Oklahoma State Medical Association recommends that the present Federal statutes be amended to provide that the Veterans Administration hospitals provide care only for service connected disabilities, and

BE IT FURTHER RESOLVED that a copy of this Resolution be forwarded to the American Medical Association, recommending its adoption by that body, and

BE IT FURTHER RESOLVED that a copy be forwarded to all senators and congressmen representing the State of Oklahoma in the Congress of the United States.

RESOLUTION
MEDICAL ASSISTANTS SOCIETY

WHEREAS, the quality and quantity of medical care available to the public today is dependent to such a great extent upon the ability, training and interest of the Medical Assistants serving in the offices of the physicians of this State, and

WHEREAS, these Assistants play a definite and most important role in the relationship of the doctor and his patient, and

WHEREAS, these Assistants, by their tactful and diplomatic handling of the situations which constantly arise, are of untold service to both the physicians and the patient, and

WHEREAS, a large number of Medical Assistants of the State have organized themselves into the Oklahoma Medical Assistants Society for the purpose of improving their own efficiency and their value and their value to the doctor and his patients,

NOW THEREFORE, BE IT RESOLVED that the Oklahoma Medical Association fully recognizes the value of the Oklahoma Medical Assistants Society and encourages its continued progress as a most effective means of better relations between the medical profession and the people of this State.

RESOLUTION
WOMAN'S AUXILIARY

WHEREAS, it has long been the belief of the Oklahoma State Medical Association that the physician and his family have a very real responsibility not only to administer to the ills of the community, but as citizens of the community, and

WHEREAS, the Woman's Auxiliary to the Oklahoma State Medical Association has been a most effective means through which the citizenship responsibilities of the physician and his family to the community can be discharged, and

WHEREAS, the Auxiliary holds itself in constant readiness to assist the Association in the development of its various projects aimed at safeguarding the health and welfare of this State, and

WHEREAS, there are many fields of endeavor in which the members of the Auxiliary can render much more effective service than can be rendered by the members of the Association,

NOW THEREFORE, BE IT RESOLVED that the Oklahoma State Medical Association urges that each Component Society continually support and assist the activities of the Woman's Auxiliary, and

BE IT FURTHER RESOLVED that this House of Delegates expresses the gratitude of the entire membership of this Association for the untiring efforts of the Auxiliary in bringing about a more satisfactory relationship between the Medical Profession and the people of this State.

RESOLUTION
MEDICAL SERVICE SOCIETY

WHEREAS, the constant development of new products for the treatment of disease is one of the primary means whereby the medical profession has been enabled to constantly raise the standards of medical care, and

WHEREAS, the introduction of such new products to the profession is so effectively handled by the representatives of the various pharmaceutical and biological manufacturers, and

WHEREAS, these representatives have organized themselves into the Medical Service Society for the purpose of improving their relationship with the profession and with each other, and

WHEREAS, the Medical Service Society and its members have at all times been ready and willing to accept their responsibilities and to cooperate fully with the Medical Profession, and

WHEREAS, the Medical Service Society has given unstintingly in its contributions of time, energy, and financing in connection with the development of the Oklahoma Medical Research Foundation,

NOW THEREFORE, BE IT RESOLVED that the Oklahoma State Medical Association recognizes the contributions of the Medical Service Society to the improvement of medical care in the State of Oklahoma and commends the Medical Service Society for its continued spirit of cooperation, and

BE IT FURTHER RESOLVED that the Oklahoma State Medical Association stands ready at all time to assist in the continued growth and expansion of the Medical Service Society, and

BE IT FURTHER RESOLVED that copies of this resolution be placed in the hands of the firms represented by the members of the Medical Service Society in this State.

A Resolution concerning the Narcotic Investigation of the House of Representatives of the Oklahoma Legislature was submitted by the Resolutions Committee and upon motion by Louis H. Ritzhaupt, M.D., of Guthrie, and duly secouded, the following motion was adopted:

"That the officers of the Association contact the Hon. James C. Nance, Speaker of the House of Representatives, and advise Speaker Nance that the House of Delegates commend the work of the Narcotics Investigating Committee of the House of Representatives, and request that the Investigation Committee make available to the Oklahoma State Medical Association and the Oklahoma Medical Board of Examiners, the testimony it has developed pertaining to Doctors of Medicine practicing in Oklahoma, who may be violating the narcotic, barbiturate and amphetamine laws."

This motion was passed by the House.

Following the consideration of the Resolutions, the Speaker announced that Doctor McClain Rogers of Clinton was attending his 50th meeting of the House of Delegates. A standing vote of congratulations was given Doctor Rogers.

Next, Wm. N. Weaver, M.D., Chairman of the Committee on Constitution and By-laws submitted the following:

"Amend Chapter V, Section 5, Page 42, by striking the present Section 5, and inserting in lieu thereof the following words and figures:

"Section 5, Nomination of Councilors

(a) Nomination Petitions

The nomination of candidates for Councilor and Vice-Councilor for the Districts as provided for in Campter IV, Section 1, shall be by nomination petitions from the Councilor Districts. Such petitions shall be signed by not less than five (5) active members in good standing in the District for which the nomination is made, and in all Districts containing more than one county such petitions shall contain the signatures of active members in good standing from at least three (3) different counties in the district.

At least ninety (90) days before each Annual Meeting the Executive Secretary shall notify each Component Society in each District for which Councilors and Vice-Councilors are to be elected of the fact that such election is to be held at the coming annual meeting and that nomination petitions must be filed in the Executive Office at least ten (10) days prior to the Annual Meeting in order for nominees to be voted upon by the House of Delegates. The Executive Secretary shall also provide appropriate forms for the preparation of such nomination petitions.

(b) Election of Councilors

Election of Councilors shall be conducted as provided in Section 1. of this Chapter, except that no election shall be held to fill the office of Councilor or Vice-Councilor for which no nomination petition has been received. The office of Councilor or Vice-Councilor for which no nomination petition has been received shall be filled by election by the Council at a meeting called during the Anual Meeting, and Councilors or Vice-Councilor so elected by the Council shall be elected for a term covering the period from the Annual Meeting at which elected to the next Annual Meeting at which time the office shall be considered vacant and nomination petitions from the District shall be in order for the remainder of the prescribed three (3) year term."

This amendment was not adopted.

The next Amendment presented by the Committee and recommendation of its adoption made, was as follows:

"Amend Chapter III, Section 6, Page 41, by striking the entire section and inserting in lieu thereof the following words and figures:

"Section 6. Memorials and Resolutions

Any memorial or resolution issued in the name of the Oklahoma State Medical Association must be approved by the House of Delegates, except for Resolutions approved by the Council when the House of Delegates is not in session. The House of Delegates shall consider only those memorials and resolutions which have been filed with the Executive Secretary at least thirty (30) days prior to the Session of the House of Delegates at which they are to be considered and which are signed by an active member in good standing of the Association or by the Secretary of a Component Society of the Association on behalf of the Component Society submitting such memorial or resolution. Memorials or resolutions may be referred by the Council to the House of Delegates for consideration by the House of Delegates without the necessity for prior filing as otherwise required by this section, provided, however, that any memorial or resolution to be presented to the Council after the thirty (30) days prior to the Session of the House of Delegates unless originated in and initiated by the Council, must be submitted to the Council by a Component Society."

As recommended by the Committee, this Amendment was approved by the House of Delegates.

Following the consideration of Amendments to the Constitution and By-laws, the Speaker asked if there were any miscellaneous or new business to come before the House. None was forthcoming.

Next was the matter of amalgamation of Seminole-Hughes Counties. L. C. Kuyrkendall, M.D., McAlester, moved that the Amalgamation be approved. M. H. Newman, M.D., seconded. Motion carried.

The next matter to be considered was the matter of Life Memberships listed in the Council report as follows:

George S. Barber, M.D., Lawton

Wm. LeRoy Bonnell, M.D., Chickasha

W. L. Cary, M.D., Reydon

E. S. Kilpatrick, M.D., Elk City

C. B. McMillan, M.D., Gracemont

O. A. Pierson, M.D., Woodward

W. E. Seba, M.D., Leedey

C. W. Tedrowe, M.D., Woodward

Ernest R. Valberg, M.D., Oklahoma City

R. Q. Goodwin, M.D., moved that the name of Ernest R. Vahlberg, M.D., be stricken from the list. Motion seconded and carried.

Doctor Goodwin also moved that the balance of the list be voted to Life Membership. Motion seconded and carried.

The matter of Honorary Membership for Roscoe C. Baker, M.D., Enid, was presented. Louis Ritzhaupt, M.D., moved that Doctor Baker be made an Honorary member. Doctor John F. Burton seconded. Motion carried.

The Speaker presented the name of Carl R. Doering, M.D., Norman, for Associate Membership. T. A. Ragan, M.D., Norman, moved that Doctor Doering be made an Associate Member. Motion seconded and carried.

At this point the Speaker asked Keiller Haynie, M.D., Alternate Speaker of the House, to take the Chair and conduct the Election.

Doctor Haynie called for nominations from the floor for the various offices. None was forthcoming. Doctor Haynie announced that inasmuch as each nomination was without opposition, it would be in order to elect all officers by acclamation. Doctor Charles Ohl of Chickasha, moved that all officers be elected by acclamation. Motion seconded and carried, and the following officers were elected:

PRESIDENT-ELECT—Bruce Hinson, M.D., Enid

DELEGATE TO A. M. A.—John Burton, M.D., Oklahoma City

ALTERNATE DELEGATE TO A. M. A.—Malcom Phelps, M.D., El Reno

VICE-PRESIDENT—Ralph Smith, M.D., Oklahoma City

SECRETARY-TREASURER-EDITOR — Lewis J. Moorman, M.D., Oklahoma City

Malcom Phelps, M.D., moved, that the Councilors also be elected by acclamation. Motion seconded and carried. The following Councilors were elected.

District # 1 Councilor—F. S. Etter, M.D., Bartlesville

Vice-Councilor—J. E. Highland, M.D., Miami

District # 4 Councilor—L. R. Kirby, M.D., Cherokee

Vice-Councilor—Joe L. Duer, M.D., Woodward

District # 7 Councilor—Paul Gallaher, M.D., Shawnee

Vice-Councilor—Charles Smith, M.D., Norman

District #10 Councilor—E. H. Shuller, M.D., McAlester

Vice-Councilor—Paul Kernek, M.D., Holdenville

District #13 Councilor—H. M. McClure, M.D., Chickasha

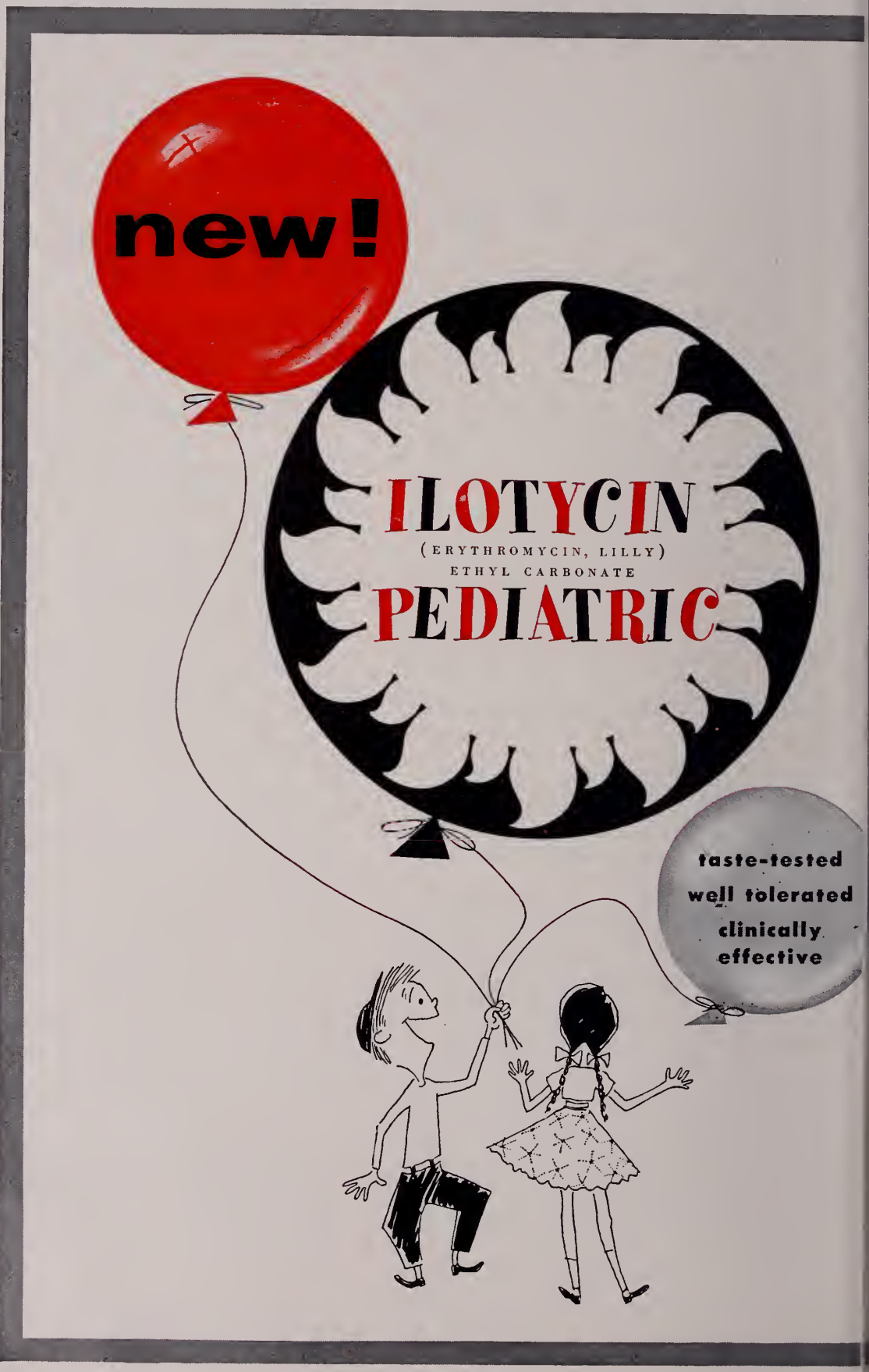
Vice-Councilor—J. B. Miles, M.D., Anadarko

District # 3 Councilor—C. M. Hodgson, M.D., Kingfisher

Vice-Councilor—Wm. P. Neilson, M.D., Enid

Vice Speaker Haynie called all officers to the front to be introduced, and as there was no more business to come before the House, the meeting was closed.

Reported By: Mary O'Leary.


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THE JOURNAL

of the

OKLAHOMA STATE MEDICAL ASSOCIATION

EDITORIALS

THE NEW VETERANS ADMINISTRATION HOSPITAL AND THE MEDICAL SCHOOL

In view of what has been said of the University of Oklahoma Medical School, this is "V. A." meaning "very apropos". Clarence E. Bates, M.D., Manager of the V. A. Hospital is a graduate of the Medical School. It is fitting that he should preside over the opening of the great V. A. Hospital adjacent to his alma mater and help to negotiate the plans for effective cooperation and affiliation in the care of the sick and the pursuit of medical education. Though this 10 story, 496 bed, completely appointed hospital might well be considered an adequate medical center within itself, it becomes a unit in the University Medical Center.

Because of this affiliation with a large staff of consulting specialists from the Medical School faculty, this hospital will attract problem cases and thereby augment its educational values for both graduate and undergraduate medical students. This feature of the affiliation significantly advances the cause of clinical research.

In keeping with the cooperative plan, for the time being Doctor Bates plans to open only 260 of the 496 beds. When the move from the Will Rogers Field is accomplished, this number can be staffed with very few additional employees, thus avoiding serious immediate competition in the employment of hospital personnel.

In a personal communication Doctor Bates says, "It is the desire of Admiral Boone and the staff to render the best possible care to the disabled men and women who served our country in time of need; also to work in close affiliation with the University to make this a great treatment and teaching center". May this desire be fully realized through the advancement of scientific medicine.

SCHOOL HEALTH IN ACTION

If anything in the realm of human welfare is more important than school health, it is family health, especially for the child of pre-school age. Physicians who help bring children up to school age in good physical condition should be vitally interested in school health and the accepted requirements of a well rounded school health program. Dr. C. M. Bielstein, chairman of the State Medical Association School Health Sub-Committee, says that such a program should consist of "healthful environment, health education, and health services".

It is obvious that such a program to be successful must have the individual interest and support of all parents, teachers and physicians. Also it must have the collective cooperation and support of community agencies interested in public health and community welfare.

With these facts in mind the State Health Department, the Oklahoma Board of Education, the Oklahoma Advisory Health Council and the State Medical Association Sub-Committee on School Health have cooperated in the production of a sound film entitled "School Health in Action". As a means of visual education this picture should be a great success. Every person in the State should see it. The picture was well planned; the theme is well presented with sustained action carrying conviction. "Seeing is believing".

Every member of the State Medical Association should see and believe and cooperate in community plans to give the film a wide showing. Parents, physicians and teachers should see that every school district is converted into a community of believers.

There is no better way than to arrange for a showing of "School Health in Action". Congratulations to the State Health Department and the cooperating agencies.

AT YOUR SERVICE

Regardless of what you think of the University Hospitals and the University of Oklahoma School of Medicine, these figures should catch your eye and command your consideration. They are lifted from the *Roundup at the University of Oklahoma Medical Center*: "9,801 discharged inpatients spent a total of 131,189 days in University Hospitals . . . 1,596 babies were born during the year . . . There were 77,994 patient visits in the outpatient department. (This does *not* include treatments for X-ray therapy, physical therapy and health service.) 9,946 treatments were administered by health service. Clinical patients represented all 77 Oklahoma counties."

To one familiar with human nature in the cross section, these figures arising from Oklahoma's melting pot of human frailties, both physical and psychological, suggest misunderstandings, critical attitudes and forthright complaints. To one who has been Dean of the Medical School and Superintendent of the University Hospitals, such complaints may be real or imaginary. Regardless of their origin, they pose ominous potentialities They may act as an evil ferment or like a devastating fungus, they may spread over the culture media prepared for the growth of confidence and extend to legislative halls where appropriations for state institutions must be considered.

This may seem a far cry from the realm of the hospital administrators where the blow first falls with ominous force, but it is directly in the channel worn smooth by our human frailities.

This is not surprising when one takes into consideration the fact that according to general averages, every patient applying for services has a family of five, a number of friends and neighbors and acquaintances running in the hundreds. What a rich background for criticism and resentment especially when human weal is the issue and a tax supported institution designed for service is the alleged offender.

In any given year it would be impossible to handle 20,000 patients and a hundred thousand anxious, immediate relatives plus friends and acquaintances without a complaint. This would amount to the millennium with the closure of all hospitals. But the hospital administration and the professional staffs canot hide behind this universal manifestation of human weakness lest they expose their own shortcomings.

Applying the all inclusive concept of the art of medicine to this situation, one can imagine great improvement through well planned and carefully supervised public relations. This is most difficult because it involves not only the first contact at the admission desk but it runs the whole gamut of the patient-hospital relationship. It amounts to the patient-physician-nurse-technician-physical therapist-social service worker-student-orderly relationship.

Always to have at the front the proper person with personality traits equal to every occasion in the course of such human relationships presents an insurmountable task, an administrative impossibility. On the other hand, one wonders if sufficient attention is given to the selection of employees who must occupy the strategic points in the important field of patient-hospital relationship. While it would require genius on the part of the employees to successfully cope with every issue, the patient exercise of talent should serve as an effective solvent.

Perhaps the budget fails to provide for the employment of genuine talent.

Briefly, this discussion presents a few problems connected with a state agency which should have careful, comprehensive and charitable consideration not only by university and hospital authorities but by every citizen in the state. The University Hospitals were built by and for the people. They are answerable to the people. As heir apparent of the people, they demand mutual responsibility and cooperation.

OKLAHOMA STATE HOSPITAL ASSOCIATION
TULSA, MAYO HOTEL,
NOVEMBER 10-13

Scientific Articles

RESUSCITATION OF THE NEWBORN INFANT

ALLAN BLOXSOM, M.D.
HOUSTON, TEXAS

The problem of resuscitation of the asphyxiated newborn infant is unique[1]. One is not only concerned with the function of a lung that must operate efficiently very shortly after delivery for continued survival, but a time limit is superimposed under which adequate oxygentation must occur and continue to prevent serious nervous system changes later in the infant's life. Added to this is the fact that 50 per cent of resuscitations of the newborn infant have to be made on the premature infant who fortunately constitutes only five to seven per cent of all deliveries.

OXYGENATION OF INFANTS IN THE AIR LOCK

Weights	Number	Living	Dead
499 to 2500 grams	125 (51 per cent)	81 (65 per cent)	44 (35 per cent)
2501 to 5000 grams	121 (49 per cent)	114 (95 per cent)	6 (5 per cent)
Total	246 (100 per cent)	195 (79 per cent)	50 (21 per cent)

Premature Infant Delivery Rate 6.74 per cent

Best and Taylor[2] state that the methods of resuscitation effective in the adult are likely to fail in the newborn infant. The reason for this failure lies in the fact that the newborn infant's alveoli have failed to expand, and to provide him with a pathway of oxygenation and de-carbon dioxidination. Primarily oxygen must be made available to the infant's foetal hemoglobin and tissue cells, and carbon dioxide removed across all available tissues and all function alveolar capillary membranes. Eastman[3] correctly states that "there seems to be only one urgent indication in the treatment of asphyxia neonatorum, and that is to introduce oxygen into the circulating blood of the infant."

Behind the physiological curtain of a considerable degree of cyanosis[4] consisting of an average mean capillary unsaturation of more than 6.5 volumes per cent of oxygen in which the foetus exists in utero normally before becoming "a poor player that struts and frets his hour upon the stage and then is heard no more", exists what is believed to be an extremely valuable mechanism in initiating respiration in the newborn infant.

At this time the purpose of labor is believed to be two fold[5]. That which is most obvious is the birth of the infant. The hidden and very useful purpose found in the the prelabor contractions and pressures generated by foetus[6] to start his respirations promptly and to reshape the low cuboidal cells lining the alveolar sacs[7] to enable the alveoli of the lung to function adequately.

The full mechanism of conditioning the foetus by the mother by pressures developed at labor is (a) a variation of the pressure gradients of oxygen and carbon dioxide to condition and stimulate the respiratory center (a warm engine always starts better than a cold one), (b) a washing in and out of amniotic fluid by a minute tidal wave in an effort to prevent atelectasis at birth by a predelivery expansion of the alveoli in fluid, which is always easier, and (c) a flattening of the low cuboidal cells of the alveolar sacs by pressure in order to favor gas exchange across to the foetal hemoglobin, and to provide further, a means to maintain pulmonary pressure in the newborn infant's lungs. The above chain of events opens the short second act in the newborn infant's life during labor of the mother and should be considered the initiation of his "operation oxygenation".

The problem of resuscitation of the new-

*Presented before the General Session at the Annual Meeting of the Oklahoma State Medical Association April 13, 1953.

born infant therefore shapes itself into using the steps found in nature if a high degree of success is to be expected. The use of unphysiologic tracheal catheters and mechanical resuscitators condemned by Best and Taylor should be eliminated. The goal of every resuscitation effort must be to load the foetal hemoglobin of every anoxic infant with as much oxygen as possible, and to siphon off enough carbon dioxide to enable the respiratory center of that infant to function.

By varying the diffusion gradients of oxygen and carbon dioxide the Air Lock enables the asphyxiated newborn infant to move across all available surfaces oxygen and carbon dioxide. In addition pressures are provided to alter the shape of the low cuboidal cells lining the alveolar sacs to provide a more efficient functioning mechanism for respiration.

The normal rates of oxygenation of the newborn infant given by Crehan, Kennedy and Wood[8] are as follows:

RATES OF OXYGENATION OF NEWBORN INFANTS

Time after Delivery	Oxygen Saturation
5 minutes	67.3 per cent (Range 31 to 92 per cent)
17 minutes	89 per cent (Range 64 to 100 per cent)
2 hours	94.3 per cent (Range 90 to 99 per cent)

Total 102 normal infants

In comparison to the normal rate of oxygenation of the newborn infant, there is given in the following Table the rate of oxygenation of a handicapped newborn infant processed in the Air Lock. This chart was made by an anesthetist using an experimental Air Lock equipped to study the enclosed infant by means of an infant oximeter.

It required approximately three minutes to adjust the ear piece of the infant oximeter. After cycling in the Air Lock for six minutes (nine minutes after delivery) the oxygen saturation of the blood rose to 65 per cent. At this level the infant made his first respiratory movement. During the next 11 minutes respiratory movements were irregular, but the oxygen saturation of the blood rose to 104 per cent, showing how marvelously efficient the pulmonary tree is in oxygenating the blood when only a few alveolar sacs are expanded. It is reasonable to assume that this infant had some time purchased for him by the Air Lock in order to enable him to initiate his respirations and to fully oxygenate his blood. He was blue as ink when first placed in the Air Lock. The Air Lock is believed capable of increasing the oxygenation of the handicapped newborn infant to a point where the respiratory center can funcion and allow that infant to carry on if he is able. The forces that oxygenate the infant act in a like manner to move the excess carbon dioxide from the infant by rocking the diffusion gradients of this gas in the infant's blood.

It is believed that the asphyxiated newborn infant can absorb considerably more than 10 per cent of his oxygen requirements through his skin. It is known that 10 per cent of the oxygen requirements of the young adult can be absorbed by diffusion through the skin and upper respiratory passages when that adult is unclothed and surrounded by an atmosphere of 100 per cent oxygen[9].

It has been thought that many of the asphyxiated infants could not breathe because of the presence of a tracheal or bron-

OXYGEN SATURATION READINGS OBTAINED BY INFANT OXIMETER ON INITIATION OF RESPIRATIONS BY APNEIC INFANT BEING OXYGENATED IN THE AIRLOCK

Mother — Eclamptic

		Total sedatives over 36 hours
	Morphine sulphate	2 grains
	Meperidine hydrochloride	200 mg.
	Paraldehyde	30 cc
	Phenobarbital sodium	25 grains
	Minutes after delivery	Oximeter Readings in per cent Saturation
3	(adjustment oximeter)	15
5	(In Air Lock with cycling)	50
6	(Infant made initial gasp)	50
7		65
9	(Infant breathing irregular)	

	Pressures in Air Lock		
	3.5 lb	3 lb	1 lb
9	77	83	
10	75	86	
14	83	94	96
16	86	95	95
20	87	97	104

chial plug of mucus or fluid, and that the use of a tracheal catheter or a bronchoscopic examination, with the subsequent removal of the plug and the carrying of oxygen down the trachea would be of value. However Potter[10] states that "The presence of excessive amounts of amniotic fluid within the lungs at the time of birth is of little consequence and does not interfere with the entrance of air. The rich capillary bed of the alveolar walls absorbs fluid rapidly, and air probably enters as easily as if the excessive amounts of fluid had not been inspired."

The following table shows a series of term and premature infants processed in the Air Lock, and the incidence of fluids expressed by those infants during the process of oxygenation.

The term infant brings up fluids in 12 per cent, and the mortality rate is the same in the group bringing up fluids as it is in the group not bringing up fluids. The premature infant brings up fluids in 30 per cent. The mortality rate of the premature infant who brings up fluids is 21 per cent, whereas it is 41 per cent in the premature group that does not bring up fluids. This is suggestive that the expression of fluids in the premature infant has a most favorable effect on the outcome of that infant. It also points to the fact that any detergent or wetting agent containing a lipophyllic fraction to act on the miscid material in the pulmonary tree would be of immense value to the premature infant.

At the present time the Air Lock by the expansion of gases in the terminal bronchioles and alveloar sacs in conjunction with a detergent or wetting agent provides the best practical method of removing pulmonary fluids. The quantity of these fluids varied from a few cubic centimeters to fairly large amounts. For the most part the fluids were clear and frothy, but in a few instances they appeared to be muco-purulent. Two infants expelled blood tinged mucus, one infant having been initially worked on with a tracheal catheter.

The following table shows the advantages that can be expected from positive pressure oxygen air oxygenation of the asphyxiated newborn infant.

ADVANTAGES OF CYCLING POSITIVE PRESSURES IN ASPHYXIA NEONATORUM

1. Promotion of bronchial drainage by the expansion of gases in the pulmonary tree for the expression of fluids and secretions.
2. Provision for a more uniform alveolar aeration.
3. Increasing the absorption of oxygen through the skin and upper respiratory passages.
4. Relieving and protecting against atelectasis.
5. Providing a gentle breathing exercise.
6. Combating acute pulmonary edema.
7. Providing favorable conditions for the diffusion and use of oxygen by the asphyxiated newborn infant.
8. Providing favorable conditions for the diffusion and elimination of carbon dioxide.
9. Dispensing with the handling of the infant on the part of the physician or nurse.

In a group of 24 infants in a series reported[11] subjected to tracheal catheterization, expansion of gases in the Air Lock removed fluids in only four. In the group of 23 infants from which fluids were removed by expansion of gases in the Air Lock, the tracheal catheter was used but four times. This indicates that it is impossible to determine to any degree of accuracy which infant the tracheal catheter theoretically might benefit. On the term infant the tracheal catheter does not seem to influence the mortality rate, but its use in the premature infant is associated with an increase of over 100 per cent in the mortality rate. See the following Table.

It is hoped that the use of the tracheal catheter in the resuscitation of the premature infant be abandoned.

The next table shows the time required

EXPANSION OF GASES TO REMOVE PULMONARY FLUIDS AND SECRETIONS

INFANTS Resuscitated		Fluids Expelled				No Fluids Expelled			
		Living		Dead		Living		Dead	
499 to 2500 grams									
125	(51 per cent)	30	(79 per cent)	8	(21 per cent)	51	(59 per cent)	36	(41 per cent)
			Total	38	(30 per cent)		Total	87	(70 per cent)
2500 grams and over									
121	(49 per cent)	14	(94 per cent)	1	(6 per cent)	100	(95 per cent)	6	(5 per cent)
Total 246			Total	15	(12 per cent)		Total	106	(88 per cent)

by 100 asphyxiated newborn infants oxygenated in the Air Lock.

USE AND NON-USE OF THE TRACHEAL CATHETER FOR OXYGENATION AND REMOVAL OF PULMONARY FLUIDS IN PREMATURE INFANTS

Weights	Tracheal Catheter Used In Resuscitation	
	Living	Dead
1500 to 2500 grams	4	3
Percent	57 per cent	43 per cent
Weights	Non-Use of Tracheal Catheter In Resuscitation	
	Living	Dead
1500 to 2500 grams	24	6
Percent	80 per cent	20 per cent

The majority of term infants remained in the Air Lock for one to two hours. The majority of premature infants remained in the Air Lock for longer periods.

Of what practical value has the Air Lock been to the Hospital? The following table shows the neonatal death rates of the term infant and the premature infant for the year immediately preceeding the use of the Air Lock, and for the third year of its installation in the St. Joseph's Maternity Hospital in Houston.[12]

The mortality rate of the term infant delivered in this hospital during 1952, the third year the Air Lock was in use, fell from 63 per 10,000 in 1949, to 37 per 10,000 in 1952, a reduction of 41 per cent. This represents a salvaging of 26 term infants in every 10,000 deliveries of term infants.

The mortality rate of the premature infant delivered in this hospital during the year 1952, the third year the Air Lock was in use, fell from 2228 per 10,000 to 1504 per 10,000, a reduction of 32.5 per cent. This represents a salvaging of 724 premature infants in every 10,000 deliveries of premature infants.

The next table shows in detail the salvage of the premature infant.

It is interesting to note that the small premature infant weighing up to 1001 grams has been but little helped by the Air Lock, while the larger premature infant weighing 1001 to 2500 grams, the mortality rate has been reduced considerably.

SUMMARY

1. A final report is made on the use of the Air Lock in the oxygenation of the asphyxiated newborn infant for starting and maintaining his respirations.

2. The initial absorption of oxygen through the skin and upper respiratory tract is most important. Increasing the pressure of oxygen available for this method of absorption is a vital step in resuscitation through oxygenation.

3. The expansion of gases expels fluids and secretions from the respiratory tract. This is the only theoretical way in which fluids can be efficiently expelled from the terminal bronchioles and alveolar sacs.

4. The use of the tracheal catheter in the newborn premature infant carries a high rate of mortality and its use should be dis-

TIME REQUIRED BY INFANTS IN AIR LOCK

Weights at birth in grams	Time in Hours													
	1		2		4		8		12		24		48		Above	
	L.	D.	L.	D.	L.	D.	L.	D.	L.	D.	L.	D.	L.	D.	L.	D.
400 to 2500 gms	2	2	5	4	5	4	4	1	0	2	6	6	4	0	5	0
2500 gms and above	15	1	15	0	7	0	6	0	4	1	0	1	0	0	0	0

Note: L. indicates living
D. indicates dead

NEONATAL DEATH RATE

(First 48 Hours of Life)

St. John's Maternity Hospital, Houston, Texas

Date	Infants Delivered		Term (2500 grams and over) Deaths	Premature (Less than 2500 grams) Deaths
January 1, 1949	Prematures	377		
to	Term	5918	39	84
January 1, 1950	Total	6295	(63 per 10,000)	(2228 per 10,000)
January 1, 1952	Prematures	452	21	68
to	Term	5702	(37 per 10,000)	(1504 per 10,000)
January 1, 1953	Total	6154	(26 per 10,000)	(724 per 10,000)
Salvage				

NEONATAL DEATH RATE
(FIRST 48 HOURS OF LIFE)
Infants weighing under 2500 grams

Grams

Date	450 to 1000 (Living)		450 to 1000 (Dead)		1001 to 1500 (Living)		1001 to 1500 (Dead)	
Jan. 1, 1949 to Jan. 1, 1950	3	(8 per cent)	36	(92 per cent)	19	(46 per cent)	22	(54 per cent)
	10 per cent				11 per cent			
Jan. 1, 1951 to Sept. 1, 1951	2	(8 per cent)	24	(92 per cent)	12	(46 per cent)	14	(54 per cent)
	10 per cent				10 per cent			
	1501 to 2000 (Living)		1501 to 2000 (Dead)		2000 to 2500 (Living)		2000 to 2500 (Dead)	
Jan. 1, 1949 to Jan. 1, 1950	31	(76 per cent)	10	(24 per cent)	240	(94 per cent)	16	(6 per cent)
	11 per cent				68 per cent			
Jan. 1, 1951 to Sept. 1, 1951	19	(100 per cent)	0		178	(98 per cent)	4	(2 per cent)
	8 per cent				72 per cent			

continued.

5. The mortality rate in a large maternity hospital in Houston, three years from the date of the original installation of the Air Lock in the delivery rooms and premature nursery, has fallen for the term infant from 63 per 10,000 in 1949, to 37 per 10,000 in 1952, which represents a salvage of 26 term infants. The mortality rate of the premature infant during the first 48 hours of extrauterine life in the same period in this hospital has fallen from 2,228 per 10,000 to 1,504 per 10,000, a salvage of 724 premature infants per 10,000 premature infant deliveries.

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Meet Our Contributors

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Allan Bloxsom, M.D., Houston, guest speaker at the 1953 annual meeting, wrote "Resuscitation of the Newborn Infant through Oxygenation." Doctor Bloxsom's biographical information appears in the July issue as he had another article published at that time.

William T. Newsom, M.D. and *Emil F. Stratton, M.D.*, both of the University of Oklahoma Staff, Oklahoma City, are joint authors of "Causes of Death in Premature Infants" in this Journal. Doctor Newsom was graduated from Tulane University and Doctor Stratton was graduated from the University of Tennessee.

Howard B. Shorbe, M.D. and *William L. Waldrop, M.D.*, both of Oklahoma City, are joint authors of "Rigid Wire Fixation of Fractures in the Hand". *Doctor Shorbe* was graduated from Northwestern University School of Medicine in 1934 and has been certified by the American Board of Orthopedic Surgery and is a Fellow of the American College of Surgery and a member of the American Academy of Orthopedic Surgery. A veteran of 61 months service during World War II, he was a lt. col. at the time he was released.

Doctor Waldrop, who has also been certified by the Board of Orthopedic Surgery, received his medical education from the University of Oklahoma School of Medicine and graduated in 1942. He served residencies at Kernan General Hospital, Baltimore, Maryland; Bone and Joint Hospital, Oklahoma City; and Battey General Hospital, Rome, Georgia. He was recently released from service and also served several years during World War II as a captain.

THE MANAGEMENT OF ECLAMPSIA

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CHICKASHA, OKLAHOM

An experience with a rapidly degenerating eclamptic patient during the last year sent the essayist looking for help in the literature. The second edition of Dieckman — *Toxemias of Pregnancy* was found to be of great value, but rather hard to separate the practical material from the theoretical. Other articles, listed at the conclusion of this paper, were of additional value, but nowhere could be found a concise article outlining safe, dependable measures which could be use no matter where one practiced medicine. The purpose of this paper is to bring together pertinent thoughts and methods of management which any physician, regardless of training, can use in the management of an eclamptic patient.

Eclampsia is a disease peculiar only to pregnancy and is characterized by edema, proteinuria, hypertension, convulsions and/or coma. Only rarely does the condition arise prior to the thirtieth week of gestation, but it is frequently seen as a complication of labor and the early puerperium.

The earliest writings in medicine mention convulsions and coma as a serious complication of pregnancy, but the word eclampsia came only around 1619 from the writings of Varandaeus. Many theories as to its etiology have been promulgated, but to date no ample explanation has been found that will explain the pathological picture known as eclampsia.

During the present era of medicine eclampsia has assumed major proportions as a cause of maternal deaths and fetal deaths because of the manner in which sepsis has been controlled and the availability of whole blood replacement for hemorrhage associated with pregnancy. For the years 1946-1948, in the United States of America, 3,800 women died because of pregnancy or its complications. Of this number 1,940 died because of eclampsia. In other words, during this period of time more than half of the maternal deaths in the U. S. A. were due to eclampsia.

During the past 50 years when so many gains have been made in various fields of medicine, very little new has been added insofar as the management of the eclamptic is concerned. The most important fact learned during this half century has been that *eclampsia can be prevented in practically, if not, every case by the use of vigorous prenatal care.* To date this type of prenatal care is not available or is not sought after by many parturients. It thus behooves every physician accepting patients for delivery to be able to manage an eclamptic.

Two schools of thought exist on this subject: (a) the radical and (b) the conservative.

The radical school has taught that emptying the uterus as soon after the onset of convulsions and/or coma was the most important factor. This method of management is mentioned only to condemn it, for if this radical school be correct then what is to be for the patient who has convulsions after delivery?

The conservative teaching has been that the eclampsia should be treated and controlled before the termination of pregnancy is considered. In other words, the treatment is directed to the oliguria and anuria, the cerebral anemia and edema, and the arteriolar spasm until the patient can be delivered normally. Thus, only a rare case will have the uterus emptied surgically, and then only for obstetrical reasons rather than the eclampsia per se. Simply said, *the conservative treatment of eclampsia consists of rest*

*Presented before the General Session at the Annual Meeting of the Oklahoma State Medical Association April 13, 1953.

and sedation with vigorous attempts to produce water elimination.

The outline to follow is quite conservative and depends to a large extent upon:

(1) Constant observation of the patient by medical personnel;
(2) Modifying the treatment to meet the needs of each individual.

THE MANAGEMENT OF THE CONVULSIVE STAGE

The care of the undelivered eclamptic is most difficult because of the pregnancy and the necessity of delivery at the opportune time. The principles of care, however, apply to eclampsia at any stage of gestation.

(1) The patient is put to bed in a dark, quiet room and *all* examinations deferred until the convulsions are controlled. Frequently the most insignificant noise or manipulation will precipitate another seizure.

During the seizures the patient is protected from self-inflicted injuries by the use of bed rails and a mouth gag, but forceful restraints are never to be used. All false teeth, rings, and jewelry should be removed at once.

The position in bed is important. Pillows are not used, but the head of the bed is elevated unless severe pulmonary edema demands postural drainage. Once an hour the entire position of the body is shifted. Suction apparatus with an attached catheter is used to aspirate the vomitus, mucous, blood, or pulmonary edema. Pure oxygen is administered by nasal catheter. If reasonable doubt exists about an adequate airway, then a tracheotomy is done.

A blood pressure cuff is kept continuously on the arm, and hourly readings taken until the convulsions and coma are controlled. A retention catheter is inserted into the bladder and hourly volume determinations are made. Frequent observations are made of the catheter to make sure that it does not become plugged. As soon as controlled, the patient's perineum is shaved.

Blood is typed, rh'd and cross matched as soon as possible so as to be available to meet any needs that may arise.

The gravity of the situation must be explained to the patient's family and no visiting permitted. Nothing is more disturbing than a roomful of well-meaning, chattering visitors.

(2) MEDICATION:

Sodium Amyal in 1 gram (15 grains) doses is given intravenously until convulsions are controlled. Thereafter, sodium phenobarbital is given intramuscularly in 0.3 gram (5 grain) doses every three to five hours to control the patient.

As soon as possible 10 cc of 50 per cent solution of magnesium sulfate is given in each gluteal region and then 10 cc is given every four hours for the first 24 hours. The knee reflexes are tested before each injection of magnesium sulfate, and if absent the medication is not given. Approximately 8 to 10 grams of magnesium sulfate are necessary for a therapeutic effect. Respiratory failure from magnesium sulfate intoxication occurs only after the disappearance of the tendon reflexes. Calcium is the antidote for overdosage of magnesium sulfate, and solutions of the salt should be available.

The use of penicillin during the acute eclamptic phase is helpful in controlling infection in the respiratory system and reproductive tract. Some sulfanomide or streptomycin should be used to control the urinary tract infection which always follows the use of an indwelling catheter.

Parenteral vitamin mixtures are given with parenteral feedings until the patient is able to take them by mouth.

Blood counts are done early and anemia is corrected by giving transfusions of type and rh specific blood. Repeated hematocrit determinations are useful in determing how well hemoconcentration and dehydration are being combated. The use of concentrated solutions of serum albumin are quite helpful in mobilizing the edema fluid and promoting diuresis.

It will be noted that morphine has not been mentioned. This is intentional because it is felt that the combination with barbiturates frequently causes such depression as to seriously complicate the therapy and management of tht eclamptic. *Oversedation can not be withdrawn, but under sedation can be corrected.*

Also, it will be observed that sedatives are used in small doses, and at frequent intervals, and that the list is limited to sodium amytal, sodium phenobarbital, and magnesium sulfate. One works better with a few familiar tools. Sedatives are used only to terminate convulsions, prevent their recurrence, and control irritability. In the comatose patient care should be exercised to watch for drug idiosyncrasy.

VERIFICATION OF DIAGNOSIS:

Once the seizures are controlled, the diagnosis of eclampsia should be verified. The finding of hypertension, edema, and proteinuria along with the convulsive seizures is sufficient verification.

MEASURES TO PROMOTE HEMODILUTION AND DIURESIS:

Once the patient is relatively calm, an intravenous infusion of 500 cc of 20 per cent glucose in water is given over a period of 50-60 minutes. If there is evidence of dehydration, in spite of edema, another 500 cc of 5 per cent glucose in water should follow the initial infusion. During this time constant observation for pulmonary edema is made.

Thereafter, infusions are given in an attempt to maintain an output of 25-30 cc of urine per hour. If the patient is anuric in spite of this, then the daily fluid infusion is limited to 1500-1800 cc of 5 per cent glucose in water. If and when urine is put out, then the urine volume is added to the calculated insensible fluid loss (about 1500 cc — depending upon the season and climate), to make up the daily fluids to be administered.

SPECIAL MEASURES

In the presence of any evidence of cardiac failure the patient should be digitalized as soon as possible and maintained in a digitalized state until delivered and convalescence is smooth.

In anuric patients the use of 0.5 gram doses of procaine intravenously in 50-100 cc of 5 per cent glucose are given every four to six hours to help promote diuresis.

SPECIAL OBSERVATIONS OF PROGNOSTIC VALUE:

a. The earliest sign of impending disaster is an insidious, unexplained, and progressive fall in arterial pressure.

b. The most reliable sign of improvement is diuresis, and *until diuresis occurs, improvement has rarely taken place.*

c. The onset of any one of the following is considered serious and leads to a very guarded and grave prognosis:

1. Paroxysmal dyspnea
2. Pulmonary edema
3. Circulatory collapse and shock
4. Heart failure
5. Premature separation of the placenta
6. Cerebrovascular accidents.

THE MANAGEMENT OF THE POST CONVULSIVE STAGE

If and when the stage is controlled the patient passes into a comatose state which will gradually fade into a stuporous to lethargic state. Sedation in the form of soluble phenobarbital should be given parenterally to prevent hyperirritability and the recurrence of seizures during this period.

The use of oxygen should be continued, and aspiration of the pharynx as needed. Both urine volumes and blood pressure readings should be maintained at one to four hour intervals, depending upon the condition of the patient. The position of the patient is changed frequently. As soon as possible, a cleansing enema is given. Once the patient's condition is well-stabilized, a thorough obstetric examination and evaluation is made.

During this phase, fluid and caloric intake is maintained by parenteral glucose. As soon as possible oral feedings of high caloric liquids are begun. Magnesium sulfate is used parenterally as indicated by urinary output, cerebral irritability, and stabilization of blood pressure readings.

At this time a copious diuresis should begin, and is a most welcome prognostic sign. It should be maintained by forcing large amounts of fluids to the patient—that is the parenteral and oral intake may go as high as four to six litres daily. *At no time is the patient to be given sodium chloride or sodium bicarbonate in any form or fashion.*

THE MANAGEMENT OF THE POST PARTUM ECLAMPTIC:

Frequently—about 10 per cent—eclampsia occurs following delivery. *This fact alone should be ample evidence that Caesarean Section is not a treatment for eclampsia.*

The medical management of the post partum eclamptic should be the same as that for the ante—or intrapartum eclamptic because the disease is the same.

TERMINATION OF PREGNANCY:

Once an eclamptic is controlled as evidenced by copious diuresis for one to two days along with a stable blood pressure during this time, plus clearing of the sensorium a decision should be made concerning emptying of the uterus.

If the patient is at or near term the cervix will usually be found ripe—i. e. soft, effaced and partially dilated. The membranes should then be ruptured, which in most cases will

initiate labor. This failing, then Pitocin[R] in small doses (never more than two minims) should be given at 30 minute intervals (or a controlled intravenous infusion of Pitocin[R] in glucose) until regular contractions are occurring at five minute intervals.

During labor, sedatives and analgesics are given in liberal amounts so as to prevent a recurrence of the eclamptic state. Frequent urine volume and blood pressure determinations are important. When in doubt, oxygen should be used to prevent fetal and maternal anoxemia.

Whenever the fetus is viable every effort should be made to protect it from excessive sedation as well as traumatic delivery. This assumes more importance when it is realized that many eclamptics deliver prematurely.

Delivery should be accomplished under local block anesthesia because the controlled eclamptic tolerates poorly both general and spinal anesthesia. Prolonged and difficult operative procedures are to be avoided if at all possible. Delivery should, however, be facilitated by low outlet forcep delivery with episiotomy when indicated.

An occasional controlled eclamptic will be found to have a long, rigid, undilated cervix which defies induction of labor. If the fetus is viable, delivery should be accomplished by Caesarean section under local block anesthesia. General or spinal anesthesia is definitely contraindicated except in the hands of an expert anesthesiologist. Vigorous care and management is quite necessary following operative delivery to prevent the recurrence of convulsions. Many eclamptics have had their fate sealed by the injudicious use of section for delivery.

GENERAL CONSIDERATIONS:

The occurrence of eclampsia with control at 32-36 weeks gestation adds the problem of fetal viability. Should the patient be well controlled, careful waiting can be instituted to allow for fetal maturity. This period is always fraught with the danger of recurrence of eclampsia and the period should never be longer than four weeks from the onset of the eclamptic state. Permanent cardiovascular damage may frequently occur after four weeks of severe preeclampsia or eclampsia.

After delivery ten to fourteen days of observation are necessary before dismissal from the hospital. All patients should be convinced of the necessity of frequent checks in the future. Further childbearing is best postponed two to three years. In the older eclamptic, consideration should be given to prevention of future pregnancies by some form of sterilization.

SUMMARY

(1) No claims of originality are made, but rather an attempt is made to bring together some pertinent ideas from several sources.

(2) No series of cases is presented, and no special claims are made.

(3) The ultra conservative management of eclampsia is heartily endorsed. One such method of management is outlined.

(4) Caution is advised concerning the use of highly technical means of eclampsia management.

(5) In the management of eclampsia there is no substitute for constant personal care and observation along with individualization of treatment.

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CAUSES OF DEATH IN PREMATURE INFANTS

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The causes of death in premature infants deserve major interest because of the high mortality. Reports of the Oklahoma State Health Department have been analyzed to point out major causes of death in the pediatric age group. There were approximately 2000 deaths from the seven leading causes for death in the age group one through 15 in Oklahoma in the five year period 1945 through 1949. For comparison, as shown in Table 1, in a projected five year period, there would be at least 3000 deaths in premature infants (based on an average of 50,000 live births annually in Oklahoma, with a six per cent incidence of prematurity, and a minimum mortality rate of 20 per cent in these infants[1]).

TABLE 1

Ages 1-15 years (1945-1949)		
Fatal injuries		1124
Pneumonia	333	
Poliomyelitis	130	
Congenital defects	122	882
Cancer	114	
Tuberculosis	111	
Heart disease	72	
Total (1-15 years)		2006
Deaths associated with prematurity	.....	3000

LEADING CAUSES FOR DEATHS IN INFANTS AND CHILDREN IN OKLAHOMA IN A FIVE YEAR PERIOD.[1]

Until effective application of the technics for preventing prematurity can be accomplished, a major objective should be to prevent, treat, or modify the conditions responsible for deaths in premature infants. To carry out this objective, it is essential that we understand the various causes for death in prematures and not be satisfied with the cursory diagnosis of "too small to live".

It has been common in the past to classify any infant weighing less than 1000 grams (two pounds, three ounces) as "previable." However, an increasing number of infants weighing less than 1000 grams at birth are being reported as surviving. One infant weighing only 397 grams (14 ounces) on the second day of life is reported to have survived and to have weighed at one year 13 pounds and 12 ounces.[2] Maturity of various organ systems does not correlate absolutely with birth weight; therefore it is impossible to decide with certainty during the life of any particular infant that this one is "too small to live". We must have faith in the tremendous growth capacities of prematures and give them the proper care to encourage their survival.

With careful postmortem examination a satisfactory cause for death can be found in almost all premature infants that die. In the largest series of autopsied prematures yet reported the cause for death in almost half of the cases is described as "abnormal pulmonary ventilation". Almost all of these presented some degree of what we now call hyaline membrane disease. The results of this study by Bundensen, Potter, et al is shown in Table 2.[3]

TABLE 2

Abnormal pulmonary ventilation	47.4 per cent
Injury at birth	16.1 per cent
Malformations	13.5 per cent
Infections	13.2 per cent
Miscellaneous	9.8 per cent

CAUSES FOR DEATH IN 3,709 AUTOPSIED PREMATURES, 1000-2500 GRAMS.

(Adapted from Bundensen, et al[3])

RESULTS

An analysis of causes for death in premature infants at University and Crippled Children's Hospitals during the years 1951 and 1952 has been made. Any newborn with at least a heart beat and weighing five and a half pounds or less is considered a live born premature. Sixty-six prematures who had autopsies are reported here, some were born at University Hospital and some were admitted from neighboring counties. The results are shown in Table 3.

*Presented before the General Session at the Annual Meeting of the Oklahoma State Medical Association April 13, 1953.

TABLE 3

Hyaline membrane disease	22
Intracranial hemorrhage	20
Malformations	7
Infection	7
Miscellaneous	8
Prematurity	2
Total	66

CAUSES FOR DEATH IN PREMATURES, UNIVERSITY AND CRIPPLED CHILDREN'S HOSPITAL, 1951-1952.

DISCUSSION

Our findings are in agreement with an earlier report of Russell[4] in that the majority of deaths in prematures occur within the first 24-48 hours of life. In prematures delivered at University Hospital we have found no deaths due to inadequacies of our standard resuscitation technics.

The ultimate decision as to cause for death rests with the pathologists, however, in the absence of satisfactory postmortem examination, the clinical course of infants having early deaths can be highly reliable in assigning a probable cause for death.

The clinical picture of an infant with pulmonary hyaline membrane disease is very characteristic. The infant usually appears normal at birth. However, within one or more hours he becomes progressively cyanotic, having rapid respirations and marked retraction of the soft tissues around the thorax. Fine rales may be heard over the entire lung field. Despite a tremendous respiratory activity, the cyanosis proceeds until terminally apnea and death occur on an anoxic basis. The duration of life in 19 cases studied was two to 48 hours, with an average of 19 hours. Some infants may recover from non-fatal degrees of this disease. High humidity in the incubator may improve some cases. A completely satisfactory method of preventing or treating this disease is yet to be learned.

The diagnosis of intracranial hemorrhage comprises two major categories, namely, traumatic birth injury and anoxic hemorrhages associated primarily with obstetric complications such as abruptio placenta or prolasped cord. Exact distinction between these types, even with careful postmortem examination, is extremely difficult and often impossible. The characteristic clinical course of an infant with intracranial hemorrhage is strikingly different from one with hyaline membrane disease in that he has a normal color as long as his respiratory activity is adequate. Apnea or other severe limitations of respiratory activity due to pathology of the respiratory center will lead to cyanosis despite the presence of an adequate pulmonary system. The infant may have only one episode of apnea, that being terminal, or he may have several from which he can be stimulated to again breathe normally for unpredictable periods of time. The duration of life in 16 autopsied cases in this series was from one-half to 53 hours, an average of 17 hours. There can be no doubt that many surviving children with mental or neuromuscular imperfections have had intracranial hemorrhages in the newborn period as their basic pathology. There is now no known effective therapy for intracranial hemorrhage; prevention is our only hope.

Deaths from congenital anomalies other than gross malformation may be detected only by careful postmortem study. Fatal anomalies of the cardiovascular and central nervous systems are not at all uncommon in prematures.

With improved nursery technics, modern chemotherapy, and early diagnosis, deaths from infections have become much less common than they were 15 to 20 years ago. Our criteria for suspecting an early infection in a premature are anorexia, weight loss, vomiting or diarrhea, and a subnormal temperature. An experienced nurse's comment that the baby "just doesn't act right" must be given careful attention. With early diagnosis and treatment our experience has been to observe marked recovery potentialities in prematures with early infections.

CONCLUSION

1. Hyaline membrane disease and intracranial hemorrhage combined account for two thirds of the deaths in prematures. There is an urgent need for effective methods of prevention, and treatment or modification of these two leading causes of death.

2. It is felt that through better understanding and reporting of the causes of death in premature infants specific efforts can be directed so as to reduce these major causes of death in the first 15 years of life.

The authors wish to express their appreciation to Doctors Hopps and Obert and Miss Jeane Greene of the Department of Medicine and Pathology of the University of Oklahoma School of Medicine for their assistance in making this study.

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HYALINE MEMBRANE DISEASE PATHOLOGY, ETIOLOGY and PATHOGENESIS

PAUL M. OBERT, M.D.

OKLAHOMA CITY, OKLAHOMA

Annually in Oklahoma an estimated 400 infants die within the first 48 hours of life with a hyaline membrane lining in their lungs. The entity resulting from this pathologic change is most commonly termed "pulmonary hyaline membrane disease of the newborn", and is the cause of death in most of these infants.

Half a century has elasped since Hochheim first reported, in a series of 43 autopsies on newborn infants, the existence of a peculiar membrane in the lungs of two of these. Since then numerous papers have been presented on this subject. In only the past few years has there been general awareness of this disease and, until recently, little attention has been given to this entity as a primary cause of death. It is now generally accepted that one of the most common causes of death in the newborn is hyaline membrane disease. Many terms have been applied to this condition, most of these reflecting the presumed etiology. Some of the more common terms that have been applied are: asphyxial membrane, aspiration pneumonia, vernix membrane, fibrinoid exudate, and eosinophilic membrane.

Pulmonary hyaline membranes of the newborn have been described in premature babies as little as 500 gm., and in full term babies. However, the incidence is highest in premature infants with a birth weight between 1000 and 2000 gm. This group of infants accounts for approximately 50 per cent of the cases of hyaline membrane disease. Approximately 50 per cent of the deaths in the group with a birth weight between 1000 and 2000 gm. are found at autopsy to present pulmonary hyaline membranes. Approximately 85 per cent of deaths from hyaline membrane disease occur within 48 hours after birth. Miller, et al, have described hyaline material lying in the lumina of air passages of stillborn prematures, but typical pulmonary hyaline membrane has never been described in infants dying within the first hour of life. After the sixth day of life pulmonary membranes are seldom present, although infants up to 14 days postpartum have been described with this change. It is encountered with the same frequency in both sexes and in all races. Blystad, Landing, and Smith noted that histories of babies, who were found at autopsy to have pulmonary hyaline membranes, revealed a relatively greater frequency of cesarean section, fetal distress, and placenta praevia, when compared with those who did not show membranes. Babies delivered of diabetic mothers, by section, showed a slight increase in incidence of hyaline membranes. The only definite predisposing cause known is prematurity. The reason premature infants most commonly manifest this change has not as yet been explained.

Gross autopsy findings are not diagnostic, although there are characteristic changes. Lungs show diffuse atelectasis and though the infants may have lived for several hours or days, many lungs are completely non-air-containing, and sink rapidly when placed in water. Lungs of infants may show similar gross changes, however, from tracheal or bronchial obstruction by mucus or other foreign debris. Death is typically that of asphyxiation. Throughout the body there are multiple, discrete, petechial hemorrhages, especially over mucous membranes and serous surfaces. There may be areas of hemorrhage in the medulla producing death indirectly by involving the vital centers. Occasionally there is massive pulmonary hemorrhage. This may be an important contributing cause of death.

Histologicaly the lungs show marked atelectasis with hyaline material lining the air passages. The material is homogeneous and stains red to bluish-red with hematoxylin and eosin. Typically this material is plastered against the walls. Infrequently it lies free within the lumina of the small respiratory bronchioles, alveolar ducts, and occasionally within the alveoli. Usually degenerated squamous epithelial cells, derived from aspirated amniotic fluid, are seen lying

*Presented before the General Session at the Annual Meeting of the Oklahoma State Medical Association April 13, 1953.

within the hyaline membrane and often these are seen between the surface of the air passage and the membrane. At first glance it appears that the amount of hyaline material is not sufficient to produce marked extensive atelectasis. On more careful examination, and with the aid of elastic fiber stains to outline the air passages, it has been shown that the hyaline material predominantly lines the small respiratory bronchioles and alveolar ducts. Very few alveoli contain the material. By obstructing the flow of air from the small air passages to the alveoli, large segments of lung become atelectatic from the presence of relatively small amounts of hyaline membrane. Multiple histologic sections from all lobes of both lungs have shown the membrane to be widespread and evenly distributed. Hemorrhage and acute inflammatory cell infiltration is sometimes associated with the hyaline membrane, however many lungs show neither of these changes, indicating they are not necessarily a part of the microscopic picture. The liver and heart frequently show fatty change and parenchymatous degeneration. These pathological changes are secondary to marked hypoxia, which is a constant clinical manifestation.

The term hyaline membrane is purely desriptive. It cannot be assumed that all hyaline membranes are identical, in spite of their morphologic similarity. The nature of the membranes covering the surface of the respiratory passages has not been definitely established. To date, histochemical studies have shown all membranes to be of essentially the same chemical composition. Membranes are composed primarily of proteins, lipids, and polysaccharides. Stains for fibrin, mucus, and amyloid are negative and numerous other types of stains have shown no characteristic feature.

Pulmonary hyaline membranes are not peculiar to lungs of newborn infants. Numerous pathologists have described an eosinophilic coating of the inner surfaces of alveoli, respiratory bronchioles, and alveolar ducts in older children and adults dying of a variety of diseases. A hyaline-like membrane lining the air spaces was first described in plague by Strong, Crowell and Teague. Since that time there have been numerous reports of hyaline-like membranes in a wide variety of inflammatory diseases and other conditions. The most common of these in which membranes have been described are influenza, rheumatic pneumonia, lobar pneumonia, uremia, influenzal pneumonia, and numerous war gas poisonings. To date no histochemical difference has been demonstarted in the pulmonary membranes of newborn and older individuals. All staining reactions are also similar. The major significant difference in the lungs of older individuals and the lungs of infants is the lack of atelectasis associated with the membranes in older children and adults.

The origin of pulmonary hyaline membranes in newborns is still unknown. Attempts have been made to reproduce pulmonary hyaline membranes since 1925, when these were first described in infants in this country by Johnson and Meyers. The authors were unable to produce membranes by injecting amniotic fluid into the trachea of experimental animals. They were, however, able to do so by introducing egg albumin intratracheally. Farber and Wilson produced lesions which they considered comparable to pulmonary hyaline membranes by the injection of India ink and dilute hydrochloric acid. They were also able to produce hyaline-like membranes by the intratracheal instillation of fibrinopurulent exudate. In 1949 Dick and Pund produced pseudo-hyaline-like membranes in the lungs of stillborn infants by intratracheal instillation of warm centrifuged amniotic fluid and, in addition, the lungs were submitted to alternating positive and negative pressure of 10 mm. of mercury. Miller and Hamilton were unable to produce hyaline membranes in dogs and rabbits by intratracheal injection of vernix, meconium, amniotic fluid, saline, Ringer's lactate solution, and distilled water. Blystad, Landing, and Smith were unable to produce hyaline-like membranes in live rats by the instillation of human amniotic fluid into the trachea. However, by injecting large amounts of amniotic fluid in repeated small amounts over a period of time they produced hyaline-like membranes in the excised lungs of guinea pigs and mice. These lungs were alternately expanded and contracted for one hour by air pressure of one pound.

A different approach to the experimental production of pulmonary hyaline membranes was first used by Farber. He was able to produce edema and hyaline-like membranes in the lungs of rabbits by performing bilateral cervical vagotomies. These animals died within eight to 24 hours and autopsy

showed occasional bronchopneumonia and hyaline-like membranes. This work was repeated by Miller, et al, and these workers were able to produce hyaline-like membranes in 13 of 20 rabbits. Histochemical preparations of the lungs of these rabbits were similar to the hyaline membranes in newborn babies.

A third experimental approach in the production of hyaline-like membranes in animals has been the use of oxygen. Many authors report pulmonary hyaline-like membranes in experimental animals after the animals have been exposed to oxygen for varying lengths of time. The most recent production of hyaline-like membranes by this procedure was by Bruns and Shields. Three adult and nine infant guinea pigs were placed in 98 per cent concentration of oxygen under normal atmospheric pressure conditions. The animals died from 38 to 119 hours after exposure. The adult guinea pigs showed pulmonary hyaline-like membranes. Two three day old guinea pigs were autopsied after being in oxygen 38 and 151 hours and both showed hyaline-like membranes. Of four one day old animals, only one had evidence of hyaline-like membranes. Four intrauterine fetuses in one of the adult guinea pig's uterus during the experiment did not show evidence of hyaline membrane formation.

Warren and Gates subjected dogs, guinea pigs, rats, and rabbits to x-ray irradiation and were able to demonstrate pulmonary hyaline-like membrane in some of these animals. Messen described hyaline-like membranes in the lungs of rabbits which died of carbon dioxide poisoning.

To date it is apparent that two basic methods have been employed in the attempt at experimental production of hyaline-like membranes. The first of these is intratracheal instillation of amniotic fluid and its constituents with autopsy of the animal after a period of respiration. It is believed by the authors who have attempted hyaline membrane production by this method, that protein and other constituents of hyaline membranes in newborn babies are derived from the amniotic fluid. It is thought that respiration must be established and maintained for a period of time for the absorption of the fluid portion of the amniotic fluid, leaving the solid portion plastered against the respiratory bronchioles, alveolar ducts, and alveoli. This concept is based on the fact that intrauterine aspiration of amniotic fluid by infants is often considerable.

The second basic method is the introduction of various substances into the respiratory tree which cause capillary endothelial damage, permitting the escape of blood proteins into the air spaces. This material then becomes plastered against the sides of the bronchioles, alveolar ducts and alveoli. It is believed by this group of investigators that formation of hyaline-like membranes in infants is comparable to those formed in older children and adults by various inflammatory processes.

Both of these methods of experimental production of hyaline membranes have been partialy successful in that some authors have been able to demonstrate hyaline-like membranes lining some of the air passages. The major significant difference in the histological picture in the lungs of experimental animals, and the lungs of newborn infants presenting pulmonary hyaline membranes, is the absence of atelectasis in all the animals in which the membrane has been produced. To date there is general agreement that hyaline membrane disease, as seen in newborn infants, has not been produced in experimental animals. It is obvious that many of the experimental methods of production by the introduction of foreign substances cannot be accepted because infants never come in contact with many of these. Pulmonary hyaline membranes have been seen in infants who have not breathed increased oxygen concentrations. Though oxygen may be a factor it is not likely the major one. At present it seems most probable that numerous factors enter into the formation of these membranes. Until the origin of this pathological change is ascertained, effective preventive measures or therapy will be difficult to establish.

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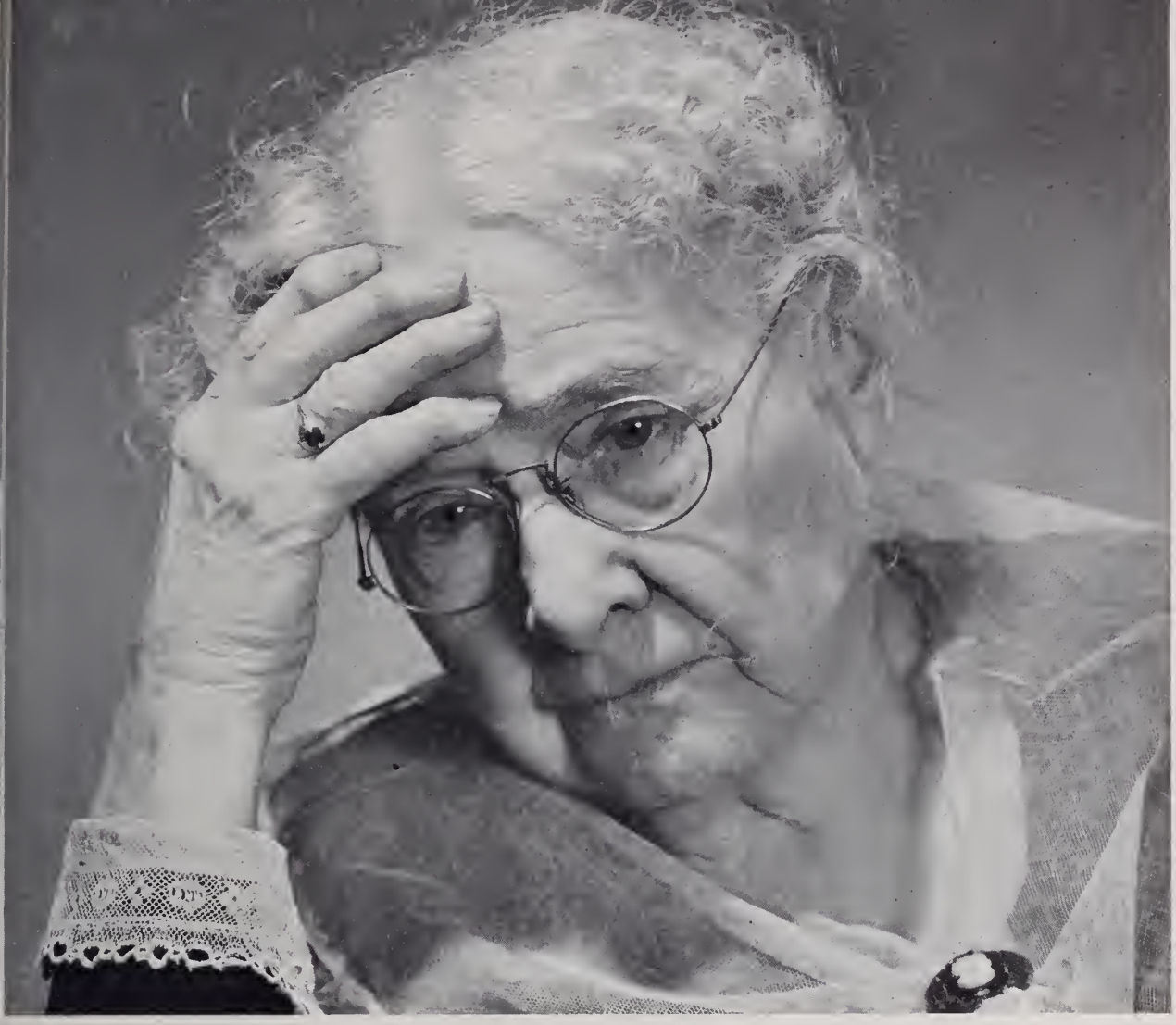
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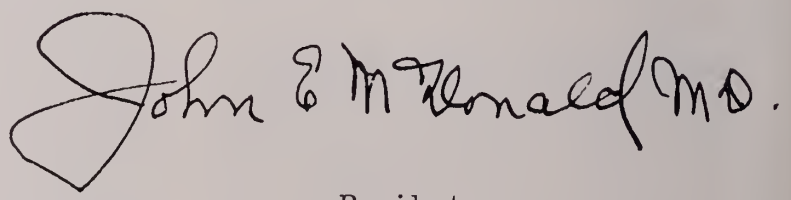
Those who have not given real thought to the problems of rural health will be inclined to question the value of a statewide rural health conference. It is all too easy to assume that "health is health" and that the development of good health in rural areas is no different than its development in any other strata of our society or economy. While such reasoning is perhaps largely true, from the standpoint of the theorist, it has long been apparent to those who have familiarized themselves with health problems as they actually exist in rural communities, that there are many factors of the rural enviornment which exert a very profound effect upon any effort to raise the health standards of rural people.

Even in these modern times, the very nature of rural life, makes it difficult for rural people to organize effectively for meeting those health needs which can only be supplied through the combined efforts of those in the community.

In spite of the prevalent romantic belief that life on the farm is the easy road to robust health, that life is fraught with constant threats to the health and safety of the individual. The maintenance of safe and palatable supplies of water, the disposal of sewage and other wastes, the constant danger of animal borne diseases and the relative isolation of the farm family are among the problems which must be met if our rural people are to enjoy the best health which modern medical science can provide. It was this realization on the part of the Sub-Committee on Rural Health which prompted the planning of the First Oklahoma Rural Health Conference to be held in Oklahoma City September 8 and 9, 1953. The Committee, in organizing this conference, wisely secured the counsel and advice of leading rural organizations in this state and of other organizations and agencies with a legitimate interest in rural health. Through these sponsoring organizations, the program for the conference was developed and some 1,500 rural leaders have been invited to attend.

In an economy such as Oklahoma's we must all be aware that problems of agriculture are the problems of us all. Agriculture in Oklahoma can flourish best when Oklahoma's agricultural population enjoys flourishing health. We all have a stake in rural health and can best protect that stake by working together with rural people in solving their health problems as they develop.

Your attendance at the first Rural Health Conference is your best opportunity to take an active part in the development of an Oklahoma rural health program in which you can believe and in which you can work hand in hand with those willing to strive together toward a common goal.

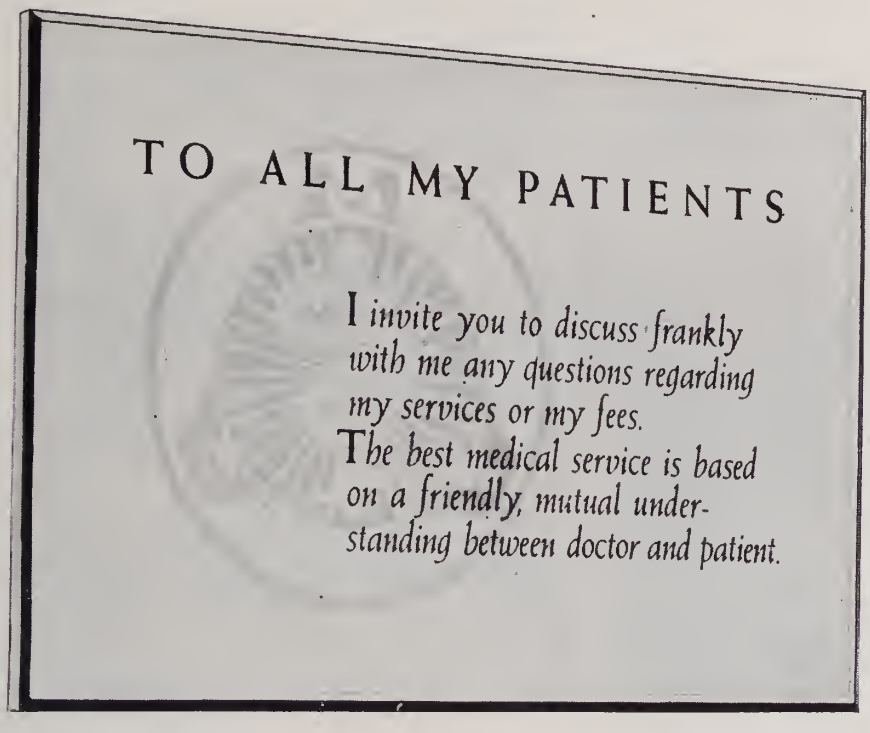


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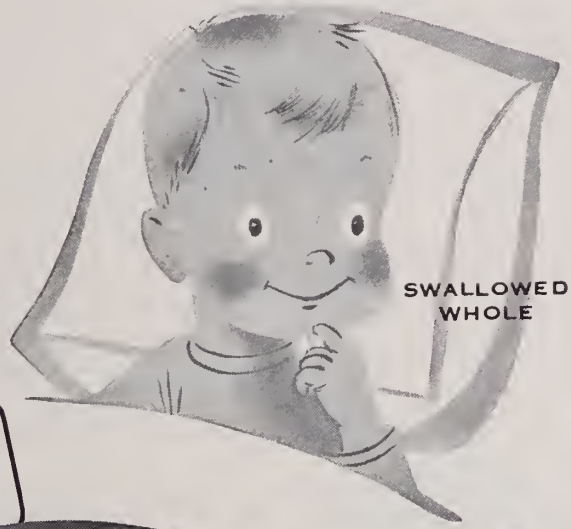
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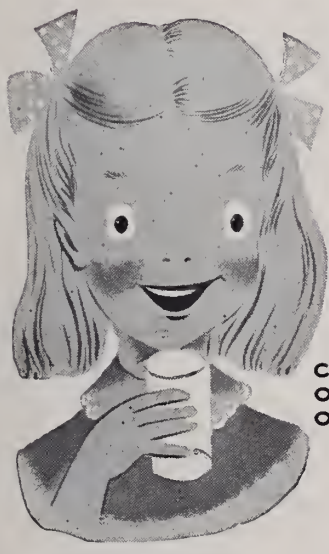
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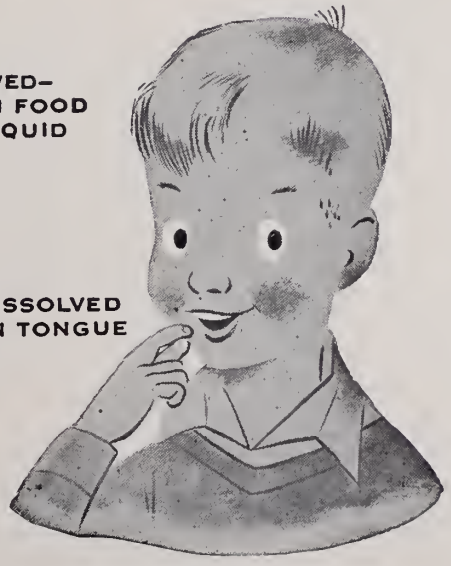
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A.C.P. REGIONAL MEETING TO BE HELD IN TULSA

The Oklahoma-Arkansas Regional Meeting of the American College of Physicians will be held in Tulsa at the Mayo Hotel September 19. Program is as follows:

MORNING SESSION

9:00 REGISTRATION

9:45 Governor's Welcome
Wann Langston, M.D., F.A.C.P., Oklahoma City

Presiding Officer
S. Charlton Shepard, M.D., F.A.C.P., Tulsa

10:00 The Use of 6-Mercaptopurine in Treatment of Leukemia
Vincel Sundgren, M.D., Associate, Tulsa

10:15 A Clinical Comparison of Anti-Cholinergic Drugs
Joe H. Hardin, M.D., Little Rock, Ark. (by invitation)

10:30 Some Aspects of Hodgkin's Disease
John W. DeVore, M.D., Oklahoma City (by invitation)

10:45 Microscopic Studies of the Human Gastric Mucosa in Vivo
Stewart Wolf, M.D., F.A.C.P., Oklahoma City

11:00 INTERMISSION

11:15 Symposium—Control of Diabetes

Presiding Officer
A. A. Blair, M.D., Governor for Arkansas

1. Dietetic Control of Diabetes
Louis Lambiotte, M.D., Fort Smith (by invitation)
2. Vascular Complications in Relation to Control of Diabetes
Bert F. Keltz, M.D., F.A.C.P., Oklahoma City
3. Use of Insulins
Earl I. Mulmed, M.D., Associate, Tulsa
4. Edward Bortz, M.D., F.A.C.P., Philadelphia
Regent of the College

12:15 Dissecting Aneurysm: Clinical Picture
Ben T. Galbraith, M.D., McAlester (by invitation)

12:30 Question and Answer Period

1:00 Luncheon

AFTERNOON SESSION

Presiding Officer
Elmer Musick, M.D., F.A.C.P., Oklahoma City

2:00 The Treatment of the More Common Cardiac Emergencies
W. W. Hamilton, M.D., Little Rock, Ark. (by invitation)

2:15 Clinical Varieties of Hypo-parathyroidism
R. Palmer Howard, M.D., Associate, Oklahoma City
Edward C. Reifenstein, M.D., F.A.C.P., Oklahoma City

2:30 Modern Management of the Diabetic
Edward L. Bortz, M.D., F.A.C.P., Regent of the College, Philadelphia

3:00 INTERMISSION

Presiding Officer
Harry A. Daniels, M.D., F.A.C.P., Oklahoma City

3:15 Symposium: Recent Advances in Cardio-Vascular Diseases

1. Clinical Indications for Valvulotomy
Cecil F. Boulden, M.D., Fort Smith, Ark. (by invitation)
2. Newer Drugs in the Treatment of Hypertension
C. L. Lewis, Jr., M.D., Tulsa (by invitation)
3. Some Practical and Theoretical Considerations in a therosclerosis
Robert H. Furman, M.D., F.A.C.P., Oklahoma City

4:15 Discussion Period

MEDICAL WRITERS' ASSN. WILL FEATURE OKLA. SPEAKERS

Oklahoma physicians are invited to attend the 10th Annual Meeting, American Medical Writers' Ass'n, to be held at the Elk's Club, Springfield, Ill., Sept. 23, under presidency of Lewis J. Moorman, M.D., Editor of the Journal of the Oklahoma Medical Association. The meeting will be held during the 18th Annual Meeting, Mississippi Valley Medical Society (September 23, 24, 25) at the same Club. The program follows:

The morning session will feature a Symposium on Medical Writing by Dr. Julius Jensen, St. Louis; Dr. Stewart G. Wolf, Jr., Oklahoma City; Dr. Theodore R. Van Dellen, Chicago; Dr. Richard M. Hewitt, Rochester, Minn. and Lee D. van Antwerp, Chicago. Also papers on Medical Writing for Medical Students by Dr. Walter R. Bett, London, England and Dr. Dean F. Smiley, Chicago. The afternoon session will feature a Symposium on Medical Writing by a non-medical group of six from the Southern Medical Journal, Mayo Clinic, Illinois State Medical Society and the Universities of Oklahoma and Michigan. The evening sesion will feature a fellowship hour, dinner, presentation of awards and fellowships and an address by Dr. Walter R. Bett of London, the distinguished British Writer and librarian. A detailed program may be secured from Harold Swanberg, M.D., Secretary, W. C. U. Bldg., Quincy, Ill. All coneerned with any phase of medical writing are cordially invited. There are no registration fees.

KANSAS CITY CONFERENCE SLATED THIS MONTH

The Kansas City Southwest Clinical Society will present the 31st Annual Conference in the Municipal Auditorium, Kansas City, Mo., September 28—October 1.

In addition to lectures before the general assemblies, these guests will participate in a panel discusion as the closing feature of each afternoon sesion excepting September 29, when the session will elose with the clinicopathologic conferenee.

Color television programs, medical and surgical have been arranged through the courtesy of Smith, Kline & French Labs., who will use two eameras to televise the program from the Kansas City General Hospital to the auditorium, thus preventing any loss of time. They also use two large screens which afford adequate vision for an audience of 500 simultaneously.

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Physicians licensed in South Dakota are reminded that legislation reeently passed has ereated an annual registration fee of $2.00. If you are lieensed in South Dakota and wish to maintain that license, payment of the registration fee should be made to the South Dakota Board of Medical Examiners, 300 First National Bank Bldg., Sioux Falls, South Dakota, by January 1, 1954.

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RURAL HEALTH CONFERENCE TO DRAW DOCTORS, RURAL GROUPS

All physicians are urged to attend the First Oklahoma State Rural Health Conference schednled for Oklahoma City September 8 and 9 at the Skirvin Hotel.

Pnrpose of the conference is to bring the rural leaders of Oklahoma together with representatives of the medical profesion and other groups concerned with health problems, for discusions as to the nature of rural health problems existing in Oklahoma and the most effective means by which those problems can be met. The conference is being sponsored by the Oklahoma State Medical Asociation with the following organizations acting as co-sponsors: Extension Service of the University of Oklahoma, Agricnltnral Extension Service of the Oklahoma A. and M. College, Oklahoma Congress of Parent-Teachers, Oklahoma Home Demonstration Connci, Oklahoma Advisory Health Council, Oklahoma Farm Bnreau Federation; Oklahoma State Dental Association, and the Oklahoma State Health Department.

The program will be bnilt around the six topics considered of greatest interest to Oklahoma's rural residents.

Majority of the speakers are Oklahomans. However, Aubrey Gates, field director of the Council on Rural Health of the A.M.A. and formerly associate director, Agricultnral Extension Service, University of Arkansas, Little Rock, will speak at the dinner meeting September 8 on "Rnral Health is Your Business."

Speaking at the luncheon September 9 will be Mrs. Charles W. Sewell, former director, Associated Women, American Farm Bureau Federation, Otterbein, Ind., whose topic will be "Let's Do It Onrselves."

Following a tour of the Oklahoma Medical Research Fonndation and the University of Oklahoma Medical Center, dnring the morning September 8, panel discnssions will be held in the afternoon on the following topics:

1. "Organizing Rnral Commnnities to Meet Their Own Health Needs," David Steen, Executive Secretary, Oklahoma Advisory Health Council, Norman.

2. "Multiple Health Screening Tests in Rural Communities," Kirk T. Mosley, M.D., Director, Division of Chronic Diseases, State Health Department; Professor, Preventive Medicine, University of Oklahoma School of Medicine, Oklahoma City.

3. "Nutrition and its Relation to Rural Health in Oklahoma," Miss Mary Leidigh, Nutritionist, Oklahoma A. and M. College, Stillwater, Okla.

4. "Animal Diseases and Their Relation to Rnral Health in Oklahoma," J. Wiley Wolff, D.V.M., Professor, and Head of Medicine and Surgery, School of Veterinary Medicine, Oklahoma A. and M. College, Stillwater.

5. "Meeting the Costs of Medical Care of Oklahoma's Farm Families, "Wayne Starkey, M.D., member, Blne Shield Board of Directors, Altus.

6. "How Rnral Oklahoma Communities Can Get Physicians," Dick Graham, Execntive Secretary, Oklahoma State Medical Association, Oklahoma City.

Wednesday morning's program will be a continuation of the group discnsions.

OFFICERS ELECTED

Recently elected officers of the Oklahoma Society of Psychiatrists and Neurologists are: A. A. Hellams, M. D., President; Harry Wilkins, M. D., Vice-President; Charles A. Smith, M.D., Secretary-Treasurer; and Neil Kimerer, M.D., member of the Execntive Committee.

HOUSE OF DELEGATES TO MEET OCTOBER 25

The House of Delegates of the Oklahoma State Medical Asociation at the Annual Meeting in Tulsa in April approved the continuation of the holding of a mid-winter meeting of the House of Delegates.

At a meeting of the Council June 21, the time of the meeting was set as October 25. This date is the Sunday immediately preceding the Oklahoma City Clinical Society. The meeting will be an all day sesion, the first part of the meeting being devoted to business of the Association and the balance of the program a discussion of social and economic problems facing the profession.

Any member of the Association is privileged to attend the meeting of the House of Delegates although delegates will be the only ones that are allowed to vote concerning the bnsiness affairs of the Association. Official call for the meeting of the Honse of Delegates will be issued by the Speaker of the House, Clinton Gallaher,, M.D., Shawnee, in the near fnture.

Delegates who represented their connty or district society at the spring meeting will be the authorized delegates for the fall meeting.

SCHOOL HEALTH CONFERENCE SCHEDULED FOR NORMAN

Sponsored by the Oklahoma School Health Administrators' Association, Oklahoma Advisory Health Council, Oklahoma State Health Department and the Oklahoma State Medical Association School Health Committee, the third annual School Health Conference will be held in Norman October 16-17.

Oklahoma physicians are nrged to attend the conference becanse of the opportunity which it gives them to assist in the planning and development of school health programs. As a result, these programs will be more satisfactory to the medical profession, the schools and will prodnce better results for the children. Physicians are reminded that the conference is scheduled for the weekend of the Oklahoma-Kansas football game in Norman, October 17, and that it is also "Dad's Day" at the University.

Theme of the conference will be a three point program covering the following: 1. Healthfnl environment; 2. Health edncation; 3. Health services.

GOVERNOR MURRAY APPOINTS MENTAL HEALTH BOARD

The 24th session of the Oklahoma Legislatnre repealed the old mental health law and enacted a new one with one of the provisions of the new legislation being the appointment of a board of mental Health composed of two physicians, one attorney and three lay persons. Appointed to the Board by Governor Murray to represent th medical profession were Mand Masterson, M.D., Oklahoma City, and Joe Tyler, M.D., Tulsa.

Governor Murray's appointments were made from a list of names submitted by the Council of the Association.

Both Doctor Tyler and Doctor Masterson served on the Association's committee to assist the House of Representatives in the investigation of the Central State Hospital.

CLAIM REPORT

As of June 1, 1953, claims totaling

$211,889.85

have been paid.

The total represents hundreds of claims paid to OMA members when disabled, through the benefits of your Association Approved

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GRIEVANCE COMMITTEE ISSUES WARNING ABOUT COLLECTION LETTERS, REFERS ONE CASE TO COUNTY MEDICAL SOCIETY

Press coverage of the recent annual meeting in Tulsa especially regarding the report of the Grievance Committee, as has been the case each year since the creation of the committee, resulted in an increase in the number of complaints filed with the committee in recent months.

Two sessions of the Grievance Committee were held during the Annual Meeting; one meeting has been held since that time and a meeting is scheduled for sometime in September.

Two cases were referred to the Council at its last meeting and the Council authorized the referral of the cases to the county society for disciplinary action and the matter is now pending a hearing of the Board of Censors of the County Society.

At the request of one county medical society, the staff and the board of control of one hospital hospital in the state, the Committee recently completed recommendations for the staff constitution and by-laws of the board of control and rules and regulations for the hospital which were unanimously adopted by the staff and the board of control. It will, it is hoped, be effective in correcting an unsatisfactory condition which had existed in regard to hospital records and regulations between members of the staff.

The Committee wishes to call attention of the membership to the importance of informing themselves as to the type of collection efforts made on their behalf by collection agencies employed by them. This was forcefully brought out in one case presented to the committee in which the following letter from a collection agency was transmitted:

> "Received your sweet letter that you turned the account over to the State Medical Association and I am sure glad as the devil that you did, for the State Medical Association will know that you don't pay your bills, and your record in the ---------- Collection Agency, ---------- Credit Bureau, and Oklahoma Credit Bureau will be absolutely N. G., and what we mean is absolutely N. G., double N. G., as far as we are concerned. You weren't even decent enough to answer any of our letters until a registered letter was sent you, then you got all hot and bothered, etc., etc., etc., so now being as you want to go to bat, we will sure go to bat and I don't mean maybe."

In this particular case, the committee felt that the fees they were attempting to collect were justifiable but that the method used was not to be condoned.

DOCTOR AMSPACHER APPOINTED SCIENTIFIC WORK CHAIRMAN

James Amspacher, M.D., Oklahoma City, an orthopedic surgeon, has been appointed by John E. McDonald, M.D., as chairman of the Scientific Work Committee of the Oklahoma State Medical Association to prepare the scientific program for the Annual Meeting to be held in Oklahoma City May 10, 11, and 12.

Any member of the Association who desires to read a scientific paper or exhibit a scientific subject should immediately contact Doctor Amspacher.

Final selection of speakers and exhibits will be announced after the first of the year.

ON ACTIVE DUTY

Oklahoma physicians who recently entered active duty in the armed forces include:

F. M. Adams, Jr. (Major), Nowata—reported to Ft. Bragg, N. C.

Jerome M. Adams (Lt.), reported to Wm. Beaumont Army Hospital, El Paso, Texas

Joseph C. Canada (Lt. Col.), Tahlequah, reported to Fort Sam Houston, San Antonio, Texas.

Robert M. Gastineau (Lt.), Oklahoma City, Fort Sam Houston

James E. Loucks (Capt.), Oklahoma City, Fort Sam Houston.

David C. Ramsay (Capt.), Ada, Camp Carson, Colo.

Robert E. Walden (Capt.—Air Force), Taft, Fort Sam Houston.

RELEASED FROM SERVICE

According to word received in the Executive Office, the following physicians have been released from service. Where possible, their last military station and present residence is given:

Ben F. Bridges (Capt.), Tulsa, Brookley Air Force Base, Alabama.

John M. Brown (Capt.), Oklahoma City, was stationed in the Far East.

Avalo V. Caldwell, Lawton, was stationed at Fort Sill.

Alan Cameron, Wagoner, was stationed in Germany.

Jenner G. Coil (Capt)., Oklahoma City, released from service at Fort Sill.

Wiley P. Dickenson (Lt.), formerly of Tecumseh, now of Ardmore, was stationed in Germany.

Charles A. Feigley (Capt.), Oklahoma City, stationed at Keesler Air Force Base, Mississippi, when released.

Clarence Robinson, Jr. (Capt.), Oklahoma City, stationed at Warren Air Force Base, Wyoming, when released.

Harry W. Vandever (Lt. jg.), Enid, released from service at Jacksonville Naval Air Training Station, Florida

Donald E. Wicker, Lawton, served with the U. S. Navy at Camp Lejuene, N. C., aboard the U.S.S. Salem in the Mediterranean and at the U. S. Navy Hospital, Memphis

HEART CONFERENCE SLATED FOR DENVER IN NOVEMBER

A postgraduate conference in "Clinical Electrocardiography, and Recent Advances in Cardiovascular Diseases" will be held in Denver, Colo., November 9-14. The conference will be sponsored by the Colorado Heart Association, University of Colorado School of Medicine, Fitzsimons Army Hospital and the Colorado Department of Public Health. No registration fee will be charged for the first three days on clinical electrocardiography to be held at Fitzsimons Hospital.

The last two and one-half days will be devoted to recent advances in cardiovascular diseases and out of state physicians will be charged $15.00 for this session to be held at the Cosmopolitan Hotel.

Further inforation can be obtained from Edwin M. Goyette, Col., M.C., Fitzsimons Army Hospital, Denver; or the Colorado Heart Association, 314 14th St., Denver.

BLUE CROSS MEMBERSHIP
NOW AVAILABLE
TO ALL OSMA MEMBERS

An Open Letter

To Members of the Oklahoma State Medical Association

At the last meeting of the House of Delegates, the Executive Office was instructed to approach the Blue Cross Hospital Plan to offer their facilities to the members of the Oklahoma State Medical Association not now enrolled.

Blue Cross has agreed to enroll all members not now enrolled in Blue Cross and under the age of 65, on November 1, 1953.

The cost of the coverage is $24.00 a year for a single person and $50.40 a year for a family, irrespective of the number of children so long as they are unmarried and under the age of 21. Please be certain in filling out the application blank that you list the names of your dependents and their birth dates.

Your application should be returned to the Executive Office, 1227 Classen Drive, Oklahoma City, **not later than October 1.** All contracts will be effective November 1.

No money is to accompany the application, as you will be billed from the Blue Cross office.

We sincerely trust that each physician will take advantage of this coverage, since it will not be possible for you to enroll after October 1, until the group is reopened next year.

REMEMBER, RETURN YOUR MEMBERSHIP APPLICATION BEFORE OCTOBER 1

Have You Heard?

O. J. Hake, M.D., formerly of Seminole and recently discharged from the army, has joined the Phelps Clinic staff in El Reno.

Richard B. Lincoln, M.D. is now associated with Moorman P. Prosser, M.D., Oklahoma City, and will limit his practice to neurology and diagnostic electroencephalography. Doctor Lincoln was graduated from the University of Oklahoma in 1944, spent three years at Will Rogers V. A. Hospital in internal medicine and has just completed a year at Illinois Neurosychiatric Institute, Chicago, where he has had training in neurology and electroencephalography under Gibbs and Gibbs.

T. H. Henley, M. D., a graduate of the University of Oklahoma, is now practicing in Canton.

G. O. Webb, M.D. has returned to Temple to practice after being associated with veterans hospitals in Arizona for some time.

Ralph R. Heine, M.D., recently discharged from the army, has joined the Community Hospital-Clinic staff at Elk City.

Melvin Fry, M.D., formerly of Tishomingo and Wright City, has recently moved to Checotah.

J. W. Ambrister, M.D., Hobart, is taking a residency in Oklahoma City.

Fred D. Switzer, M.D., formerly of Hugo and more recently of DeQueen, Ark., has joined the McAlester Clinic Staff.

Elizabeth P. Fleming, M.D., is the new health director for Atoka County.

John E. McDonald, M.D., Tulsa, O.S.M.A. president, was quoted in the July *Woman's Home Companion* article, "How Much Should Your Doctor Charge?"

William C. Click, M.D., has joined the Chickasha Hospital and Clinic staff.

O. J. Gee, M.D., Oklahoma City, has been elected National Commander of the Army and Navy Legion of Valor. He holds the Distinguished Service Cross.

STATE HAS 23 NEW PHYSICIANS

According to word received in the Executive Office, at least 23 new physicians have gone into practice in the state during June and July. The majority of the physicians are practicing in rural communities. Among the physicians who have recently opened their practices are:

Jack Alexander, M.D.—Ponca City
Charles E. Baker, M.D.—Ardmore
Lynn C. Barnes, Jr., M.D.—Nowata
Charles E. Beck, M.D.—Lindsay
Eugene S. Bell, M.D.—Tishomingo
Marion D. Christensen, M.D.—Kiowa
William Claude Click, M.D.—Chickasha
David C. Clemans, M.D.—Hartshorne
James W. Coin, Jr., M.D.—Wagoner
J. T. Colwick, Jr., M.D.—Durant
James H. Elliott, M.D.—Nowata
J. Douglas Green, M.D.—Cushing
George A. Hart, M.D.—Cherokee
William L. Hulen, M.D.—Tipton
Willie George Long, M.D.—Purcell
Arnold G. Nelson, M.D.—Chickasha
George R. Randels, M.D.—Hollis
Thomas F. Regan, M.D.—Chickasha
Richard Lee Russell, M.D.—Picher
William L. Shead, M.D.—Norman
Burl E. Stone, M.D.—Anadarko
J. L. Wheeler, M.D.—Oklahoma City
C. J. Womack, M.D.—Wister

FROM THE OKLAHOMA DIVISION, AMERICAN CANCER SOCIETY

The following communication received from the National Office of the American Cancer Society is reprinted, in its entirety, for your information.

FROM: *Medical and Scientific Director*
SUBJECT: *KOCH CANCER TREATMENT*
Rogers vs. Baldor "Florida Circuit Court"

1. The Koch treatment for cancer is perhaps the most widely employed of the unorthodox treatment methods. The *Journal* of the *American Medical Association* and its Bureau of Investigation have repeatedly condemned the promotion of Koch's "Glyoxylide," which does not appear to be based on any generally accepted concept of cancer and which, on analysis by the Federal Food & Drug Administration, does not appear to have any active ingredients.

2. In 1942, the Federal Trade Commission *instituted* litigation against Koch, as did the Food and drug Administration in the same year. The first trial resulted in a hung jury. A second trial in 1946 ended when a juror became ill.

3. In the fall of 1951, Mr. J. T. Rogers of Lutz, Florida filed a claim against Julian Baldor, M.D., for damages in the amount of $150,000 charging malpractice and abandonment. The malpractice charge was based on the fact that Mr. Rogers, suffering from biopsy-proven but apparently localized cancer of the lip, was "treated" by Dr. Baldor, who employed Koch's glyoxylide and diet as the sole treatment method. The cancer continued to grow until it involved the entire lower lip, chin and lymph nodes of the neck, ultimately requiring extensive surgery in the Tampa Municipal Hospital, in the course of which the lower jaw had to be sacrificed.

4. The Circuit Court trial was held in Tampa, Florida, March 2 to March 13, and in the course of it, depositions for the plaintiff by Dr. Alfred Gellhorn of the Francis Delafield Hospital, New York City; Dr. C. P. Rhoads of Memorial Cancer Center, New York City; Dr. Harry M. Nelson, President of the American Cancer Society, and other prominent physicians were presented. The Medical and Scientific Director of the American Cancer Society appeared for the plaintiff, testifying for several hours.

5. The jury's verdict was in favor of the plaintfiff, Rogers, and it awarded $65,000 in damages to him.

6. It is anticipated that this decision will strengthen future efforts of the Food and Drug Administration to prosecute the promotion of the Koch "cure."

Editors note: Each month in this space the Oklahoma Division, American Cancer Society will publish news in the field of cancer control of interest to our readers.

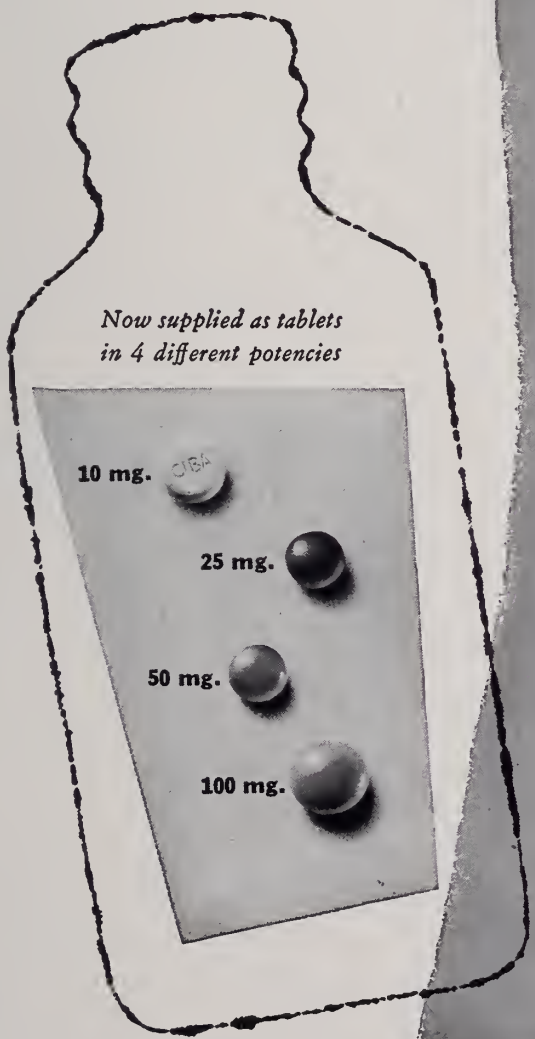
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BOOK REVIEWS

THE PSYCHOLOGY AND PSYCHOTHERAPY OF OTTO RANK by Fay B. Karpf, Ph. D. Published by Philosophical Library, New York.

The author has fulfilled the aims implied in her title in an admirable manner. She presents a brief longitudinal view of Rank's professional life including his introduction to and departure from the Freudian group.

She gives an admittedly critical examination of a few of Freud's most important basic concepts and follows this by an explanation of the reasons for the break from the Freudian school by both Jung and Adler. The major theoretical considerations and therapeutic technics of both Jung and Adler are discussed.

The remainder of the book deals with a more detailed consideration of Rank's theory and therapy. Rank is constantly compared to Freud. The reader discovers that Rank developed his system by attempting to modify and revise certain of Freud's concepts and that this practice led to his separation from the orthodox psychoanalysis.

If the breaks from Freudian psychoanalysis by Adler, Jung and Rank had been presented in chronological sequence, the total story would have unfolded in a more logical fashion and the book would have been more readable.—Robert A. Schneider, M.D.

A MANUAL OF CLINICAL ALLERGY
John M. Shelton, M.D., Robert G. Lovell, M.D. and Kenneth P. Mathews, M.D.

This book barely more than pocket-size contains information which will be useful to the allergist, internist, general practitioner and student. The passages describing the general approach to the allergic patient are particularly helpful and enable one familiar with the material to place laboratory procedures such as skin testing in their proper perspective.

Some of the chapters will be of interest primarily to the allergy specialist. One chapter, for example, contains a beautifully illustrated treatise on pollen morphology.

The criticisms are few and of minor consequence, e.g., the sentence on page 88 which states that,.....prolonged administration of penicillin may be helpful, especially against penicillin-sensitive organisms.'' The term migraine is often used in a broader sense than is ordinarily accepted.

There is a well selected small group of references to the medical literature and to sources where one can obtain materials useful in allergy practice such as allergen proof covers, cotton blankets that are free of wool, etc. —Kelly M. West, Jr., M.D.

DANGER SIGNALS. Warnings of Serious Diseases. By Walter C. Alvarez, M.D., Wilcox and Follett Company, New York, 1953.

Dr. Alvarez undoubtedly had the best of motives in writing *Danger Signals,* but it would seem the book accomplishes very little. Such a work has certain inherent handicaps, and these are faced in the preface by the author's acknowledgment that it will give rise to unfounded anxiety in many readers and that others will error in taking it as a guide for self-diagnosis and treatment. Unfortunately, its greatest appeal probably will be for the very group most likely to fall into those two categories; the majority of the warnings it lists would be self-evident reasons for consulting a physician to other readers.

The chapter on how to find a good doctor is to be commended; but not so are Doctor Alvarez's insufficient regard in this treatise for the general practitioner or for variability in symptomatology and modes of therapy in specific conditions.—Clair Liebrand, M.D.

PSYCHIATRIC DICTIONARY With Encyclopedic Treatment of Modern Terms.
Leland E. Hinsie, M.D. and Jacob Shatzky, Ph. D. Second Edition with Supplement. New York. Oxford University Press. 1953.

To attempt a clear understanding of present day psychiatry is a matter of sustained diligence with little hope of success. Those who approach the task should seek the wisdom of the Bible, the rationality of Dr. Samuel Johnson's Dictionary and the guidance of his prayers. In the latter, this helpful appeal appears; ''Almighty God, in whose hands are all the powers of man . . . be present with me in my studies and inquiries'' and ''. . . appease the tumults of my mind.''

Armed with these safeguards one may hopefully peruse this formidable Hinsie and Shatzky *Psychiatric Dictionary.* The reviewer is confident the compilers share Doctor Johnson's conception of the lexicographer's task whose only hope is to escape reproach. ''He that undertakes to compile a Dictionary, undertakes that, which, if it comprehends the full extent of his design, he knows himself unable to perform.''

The word psychiatry is not in Doctor Johnson's Dictionary but the concept was definitely in his mind. Likewise, it has occupied the minds of all successful physicians through the ages. *Sans* formal training in this special field, the common sense of the good family physician encompassed what the Distionary terms ''psychiatry'' and it was practiced with a surprising degree of success. It is interesting to note that Doctor Johnson's words beginning with ''ps'' are few. The list opens with ''psalm'' and closes with ''pshaw.'' What would be his definition of psychiatry if only he could take a look at humanity today and record his impressions.

Though the authors considered brevity their ideal, their difficulties are revealed by the encyclopedic elucidation of their definitions. This results in an intriguing treatise on the more than 8,000 words, terms and concepts appearing in the volume's 780 odd pages.

The elaborate attempt to give each definition ''vital, clinical and realistic meaning'' reminds one of Doctor Johnson's meticulous methods. In spite of this, one finds himself constantly reading between the lines. This is not surprising since obviously in medicine, and particularly in psychiatry, it is impossible to put everything on the line. This rather discursive discussion of the Dictionary is not to discredit or condemn, but rather to stress the difficulties encountered in this field, failing as it does, between what we know about the body and what we do not know about the mind.

Obviously the soma cannot function without the psyche. Every phase of our behaviour and our total response to environment, plus our acceptance of this Dictionary, hinges upon this intangible something we call psyche. As now classified by psychiatrists, the psyche is considered one of the organs of the body with ''its own form and function, its embryology, its gross and microscopic anatomy, physiology and pathology.'' Considering our present limitations, would it not be better to wait until we can finger Freud's conscious and unconcious divisions of the mind with palpable certainty and slide their numerous components under the microscope for determination of their nature, structure, and pathology.

The Second Edition of the *Psychiatric Dictionary* with its voluminous supplement containing many words not yet familiar to the profession as a whole, represents one of the best available attempts to bridge this chasm

between body and mind.

Considering the current relative importance of psychiatry, with its rapidly growing vocabulary, it behooves every wide awake physician, whether general practitioner or specialist, to have this volume at hand and call it to mind when strange words and incomphensible terms arise.—Lewis J. Moorman, M.D.

ESSENTIALS OF MEDICAL RESEARCH. Wallace Marshall, M.D., Introduction by Thurston Welton, M.D., New York. Vantage Press. 1953.
Price $3.00.

Introducing this handy little volume, Thurston Welton, M.D., Editor of the *American Journal of Surgery*, says:

"All who write scientific papers do so because they have done some type of research. It may be based on laboratory or clinical investigation. If an author has done thorough work and knows the art of presenting the results of that work by the written word, his writing will be published for others to read. Alas! In many instances the research has been superficial, a rehash, inept, and the writing not worthy of a seventh-grade schoolboy. We sugest that all young phyisicans read what Dr. Marshall has to offer, and then read other works along similar lines. The result: much drudgery will be taken from the day's work, routine affairs will become an absorbing stimulation, and the practice of medicine and general standard of medical literature will be raised to a much higher plane of excellence."

Here is a treatise not too short to be useful, not too long to be practical and not too dogmatic to be intriguing. It represents the type of writing that guarantees easy reading and presents well washed nuggets of negotiable knowledge.

Strange as it may seem, this small volume contains the essentials of research for all who are interested in the progres of science from the medical student up to the general practitioner and from the general practitioner down to the streamlined specialist.

The author has progressed from chemist, research worker, discoverer and teacher to general practitioner. He writes from the vantage point of general practice where konwledge resulting from scientific research is applied for the benefit of the patient.

The random choice of a few titles from the 29 short chapters sugests what is in store for those who read the book: "The Art of Creating," "Importance of Research in Training Students," "Publicity and Ethics," "Originality, Imagination, and the Five Senses," "Importance of Properly Controlled Studies," "How to Plan Your Research," "How to Review the Literature," "Proper Collection and Presentation of Data," "Medical Statistics," 'How to Prepare Your Report," and "Submitting Your Data for Publication."

The reviewer, who happens to be on the Editorial Board of the *Journal* recommends that every member of the State Medical Asociation read the chapters on preparation of data for publication.—Lewis J. Moorman, M.D.

Current Activities at the Oklahoma Medical Research Foundation



Dr. Charles D. Kochakian, who was formerly Associate Professor of Physiology of the University of Rochester School of Medicine and Dentistry, Rochester, New York, was recently appointed as acting Director of the Oklahoma Medical Research Institute and Hospital. He joined the staff in January, 1951.

Doctor Kochakian is an endocrine physiologist and physiological chemist who is internationally known for his work on hormones, enzymes, nutrition and growth. He has served as a member of the Panel on Hormones, of the Committee on Growth, of the National Research Council. He is also a member of the Panel of Appraisers of the Handbook on Biological Sciences. He was awarded the Claude Bernard Medal and appointed a visiting Claude Bernard Professor of the Institute of Experimental Medicine and Surgery of the University of Montreal on April 27 and 28, 1950. He is also an Associate of the Roscoe Memorial Laboratory, Bar Harbor, Maine.

Doctor Kochakian was born in Haverhill, Mass. He received his A.B. and A.M. degrees in organic chemistry from Boston University, and received his PH.D. in physiological chemistry from the University of Rochester, Rochester, New York. He is a member of a number of national societies.

In Oklahoma he is continuing his research on hormones and growth. In addition, he is in charge of a Central Research Laboratory which is being developed in the Institute and supervises the facilities for animal experimentation as well as the Graduate Training Program. Doctor Kochakian has an appointment as Professor of Research Biochemistry in the University of Oklahoma School of Medicine.

Announcements

OKLAHOMA STATE RURAL HEALTH CONFERENCE. Oklahoma City, Skirvin Hotel, September 8-9.

SOUTHWESTERN SURGICAL CONGRESS. Salt Lake City, September 21-23.

OKLAHOMA CITY CLINICAL SOCIETY. Oklahoma City, Biltmore Hotel, October 26-27-28-29.

SOUTHERN MEDICAL ASSOCIATION. Atlanta, Georgia, October 26-29.

OKLAHOMA STATE HOSPITAL ASSOCIATION. Tulsa, Mayo Hotel, November 10-13.

A.M.A. INTERIM SESSION. St. Louis, December 1-4.

OKLAHOMA ACADEMY OF GENERAL PRACTICE. Tulsa, Tulsa Hotel, February 15-16, 1954.

OKLAHOMA STATE MEDICAL ASSOCIATION. Oklahoma City, Municipal Auditorium, Oklahoma City, May 10-11-12, 1954.

AMERICAN COLLEGE OF SURGEONS. Chicago, October 5-9, Conrad Hilton Hotel.

PAN AMERICAN MEDICAL WOMEN'S ALLIANCE. Fourth congress, Beekman Towers Hotel, First Avenue and 49th St., New York City, September 24 through October 1. Registration should be mailed to Ina A. Marsh, M.D., 140 Linwood Ave., Buffalo 9, New York.

AMERICAN COLLEGE OF PHYSICIANS. Regional meeting, Tulsa, Mayo Hotel, September 19. Complete program appears elsewhere in this issue.

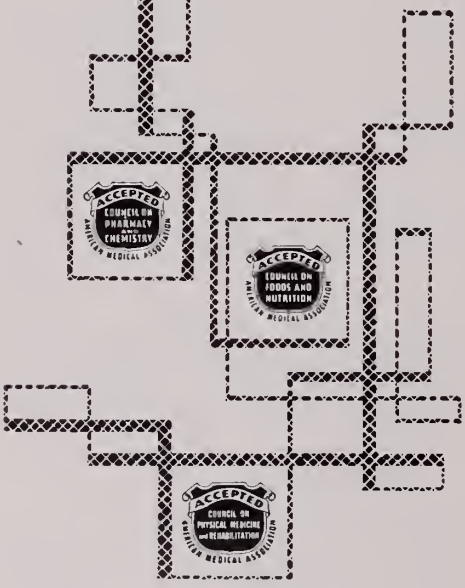
AMERICAN UROLOGICAL ASSOCIATION. New York City, Waldorf-Astoria, May 31—June 3, 1954. For further information concerning the meeting and the essay award write the Executive Secretary, William P. Didusch, 1120 North Charles Street, Baltimore, Maryland. All essays must be in his hands by February 1, 1954.

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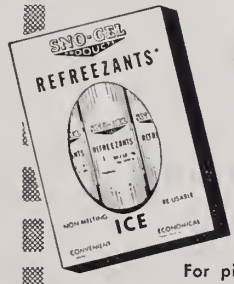
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THE JOURNAL

of the

OKLAHOMA STATE MEDICAL ASSOCIATION

EDITORIALS

FEE-SPLITTING

The returns from a questionnaire sent to executives of 47 state medical associations are rather confusing and to say the least, embarrassing. It is unfortunate that a great profession with a good name must be penalized by a few members who put money above morals.

Of the 40 states reporting, 33 indicated that fee splitting is not a problem. In seven, the answers are qualified, leaving much between the lines.

Wherever there is obvious hair-splitting over fee-splitting, there are wolves in sheep's clothing. The practice is immoral and unethical not in the strictest sense, illegal. To our chagrin, 11 of the states reporting have laws against fee splitting but all of these report non enforcement. The house cleaning should be in the profession, in organized medicine, not in the state legislatures. Physicians should never let professional perfidy reach such proportions that the public must look to the law for protection.

Whether fee splitting is practiced openly or by subterfuge, conscience is annulled and the participating physicians are suspect. Fee splitting that is not open and above board connotes deception. Deception is synonymous with dishonesty and dishonesty when a patient's interests are at stake is damnable and should not be condoned by the profession. Though beating the devil around the bush may be permissible in business, it has no place in medicine where human life is in the balance.

Every informed physician knows that the good surgeon has his established routine and technique which cannot be broken without risk to the patient. When, as a subterfuge, he says to the physician referring the patient, "You serve as my assistant and I will collect your fee," he either upsets his routine or has the physician stand by like a dummy. In either case, he is guilty of unprofessional conduct and should be disciplined in the councils of the medical profession and not in the courts. The physician who accepts the split, if not equally guilty, is robbed of self respect and he cannot escape the scars resulting from the insult to his intelligence, initiative, honor and integrity. Every physician, young or old, should place a value on his services and have the courage to collect his own fee. To be physician worthy of the name, one must first be a man. The physician who deliberately enters the trap for the cheese is a mouse.

ELMER L. HENDERSON

Sixty-eight years ago down in Kentucky southwest of the famed blue grass section, the late Elmer L. Henderson, M.D., was born. In this part of the state living came hard and freedom was prized. This is easy to understand because it was earned by the sweat of the brow. In contact with the soil, he developed a self-sufficiency which served him well when socialized medicine was the government's game and Oscar Ewing had the ball. His part in this fight for the freedom of the profession and the people is well known especially in the circle of organized medicine. After building for himself a secure position in the field of surgery, unsparingly he devoted time and effort to the cause of common weal in the field of personal freedom for both the people and the medical profession. In confirmation of this, we quote from his presidential address at the A.M.A.

annual meeting in San Francisco June 27, 1953:

"American medicine has become the blazing focal point in a fundamental struggle which may determine whether America remains free, or whether we are to become a Socialist State, under the yoke of a Government bureaucracy, dominated by selfish, cynical men who believe the American people are no longer competent to care for themselves . . . I call upon every doctor in the United States, no matter how heavy the burdens of his practice may be, to dedicate himself, not only to the protection of the people's physical health, but also to the protection of our American way of life, which is the foundation of our economic health and our political freedom."

It is reported that Elmer L. Henderson and his friend, Robert A. Taft, suffered from the same deadly disease and died within 24 hours of each other. Almost simultaneously, the people and the profession lost two militant champions.

Though Doctor Henderson was a great man, he was only a small part of a big pattern. There are many men in the medical profession who will take up the fight and help perpetrate this pattern of professional freedom.

"MAN, THE ENIGMA"

Presuming upon the friendship of Arthur C. Jacobson, M.D., Editor of **Medical Times,** we lift the following from the editorial pages of the August issue of his journal:

"Man is an inscrutable creature; on the one hand he creates 'the potential weapon of world suicide, threatening his very existence,' and on the other he utilizes radioactive isotopes to restore and normalize certain pathological aberrations, not to mention the possibility of industrial application of nuclear energy which could revolutionize present processes and make humanity comfortable, efficient without undue physical strain, and relatively happy."

PATIENTS, PHYSICIANS AND FEES

In this cold, impersonal world where reason makes light of sympathy and emotion and often chooses medicine as its target, it is good to find somebody outside the profession championing the cause of the physician where unreasonable reason fails to comprehend. Such a one is Edward Whitman who queries in the July **Woman's Home Companion,** "How Much Should Your Doctor Charge?"

Every physician should read this article and re-appraise his attitude toward his patients realizing that while they want him to be scientifically competent, most of all, they are interested in the prognosis and the cost of service. The present day pressure for time seriously limiting satisfactory communication between patient and physician and the unwarranted mutual timidity about the discussion of fees unnecessarily strains the patient-physician relationship and leads to unfortunate psychological conflicts which should never exist.

In the days when chickens and eggs, pork and venison and sometimes ponies and calves helped to make up the common currency and fees were not strictly figured on the dollar and cent scale, the problem was not so acute. Often it was easier to kill a deer than it was to find a dollar and think of the fun. "Why not give the doctor a hind quarter or the whole damn deer? The woods are full of them."

Today it is different. The dollar is the determining factor. The ditch digger has the fee scale in mind and watches the clock, oblivious of the pick and the shovel. The employer knows this, and neither he nor the ditch digger can anticipate the joy of accomplishment. Unfortunately, this situation tends to dominate our economic philosophy. People feel they should know what the cost will be and why. Physicians must realize that first of all medicine stands for service, not for gain, and they should act accordingly. They must find time to help their patients to a full realization of these facts. It is time to dust off the plaque that reads, 'To all my patients: I invite you to discuss frankly with me any question regarding my services or my fees. The best medical service is based on a friendly mutual understanding between doctor and patient."

Nearly 100 years ago Amiel said, "Why do doctors so often make mistakes? Because they are not sufficiently individual in their diagnosis or their treatment . . . The principal grievance which I have against the doctors is that they neglect the real problem, which is to seize the unity of the individual who claims their care. Their methods of investigation are far too elementary; a doctor who does not read you to the bottom is ignorant to essentials."

Scientific Articles

EVALUATING MEDICAL TESTIMONY *

Judge Tom Hieronymus
Chairman, State Industrial Commission
Oklahoma City, Okla.

In a recent article in a Tulsa paper I noted a statement to the effect that this is the first time that the State Medical Association has devoted so much time to a discussion of Industrial Medicine. I have felt that the public in general has overlooked the importance of the administration of the Workmen's Compensation Law in our State in view of its effect indirectly or, in many instances, directly on the economy of the various communities of the State, especially in cities the size of Tulsa or Oklahoma City where the large volume of the claims for injuries arise. It is certainly gratifying to see the Medical Association becoming more and more conscious of the magnitude of this field and the necessity for expert care and treatment of injured employees, and we acknowledge your efforts in preventive medicine and recommendations as to safety factors in industry.

This, I believe, can best be illustrated by calling to your attention that for the years 1951 and 1952 there were 31,922 accidents reported to the Commission and of this number, 17,507 resulted in claims, on which a total of $13,342,863.11 was paid in compensation. This figure, of course, includes the total amount of compensation paid voluntarily and also by award after hearings, but does not include the thousands of dollars spent for the treatment of those injured employees. Every payment of compensation and every award made was based upon the expert testimony and evaluation of physicians so you can readily see the value of your profession as it applies to the administration of the Workman's Compensation Law. Our law is such that only a medical expert may pass on the question of disability and the rating thereof. The Trial Commissioner must depend solely upon expert testimony to show the nature, extent and permanence of the disability resulting from accidental personal injuries received in industry and the manner and extent to which the disability affects the injured workman's ability to work or use his normal physical power.

For the benefit of those of you who may not be familiar with the schedule of injuries and the rules of the Commission as to the ratings under the Workman's Compensation Act of this State, I will briefly review that schedule:

The loss by amputation of a distal phalange of any of the fingers or toes is considered a 50 per cent loss of that member, and the amputation back of the distal joint is considered to be 100 per cent loss of that member.

Disability resulting from injury to two or more fingers or toes should be rated on the hand or foot rather than individually to each member.

On an injury occurring at some point from the elbow down (exclusive of the fingers, unless two or more are involved), the disability should be rated to the hand, while a disability rating for an injury from the shoulder to the elbow would be considered as to the arm. Likewise, as to the lower extremities, an injury from the knee down should be rated as an injury to the foot, and an injury from the hip to the knee would call for a rating as to the leg.

If an injured employee should come to you with an injury to the shoulder or hip it may well be that the disability may be limited to the arm or to the leg or to the body as a whole, and it is entirely up to you as the medical expert to determine whether or

*Presented before the Symposium on Industrial Medicine at the Annual Meeting of the Oklahoma State Medical Association, April 15, 1953.

not the rating should be as to the body as a whole or as to the member.

In rating disability where two or more major members are involved, each member should be rated separately and then, by combining the ratings to the individual members, a rating should be made as to the body as a whole.

Relative to injuries to the eyes, we generally follow the Snellen Chart; however, 80 per cent loss of vision is considered to be industrial blindness entitling the injured employee to a rating of 100 per cent of the eye. If both eyes are injured, resulting in loss of vision to both eyes, the rating should be based upon the body as a whole.

Our legislature, in 1943, in order to encourage the employment of physically impaired persons, established what is commonly referred to as the Second Injury Fund, and we have found that the doctors generally seem to have difficulty in calculating the disability as it relates to this fund. If an employee is a physically impaired person and sustains a subsequent injury it may be that the combination of the disability resulting from the subsequent injury, as combined with the previous injury or impairment, will entitle him to additional benefits from the Special Indemnity Fund. For the purpose of illustration, let us say that in 1940 a claimant lost the vision in one eye. then at a later date he suffered an injury to one of his legs. Those injuries may be combined in considering the fact as to whether or not the combination of the two injuries resulted in a disability to the body as a whole materially greater in degree than that resulting from the last injury considered alone. We are dependent entirely upon your opinion as experts as to the amount of increase of disability in such cases. While you can combine major members in considering the increase of disability to the body as a whole by reason of the two injuries, it is not permissible to combine fingers or toes, except as to an increase of disability to the hand or foot.

There is no mathematical formula to be followed in arriving at the percentage of disability an injured workman might have, and it is simply up to you doctors as experts to rate the percentage of disability based upon the permanent effect that the injury has had on the injured's ability to perform ordinary manual labor, with the limitations that the Oklahoma Workman's Compensation Act has placed on specific members. A medical expert, in expressing an opinion, either in report form or in testimony before a Trial Commissioner, should take into consideration the history given to him by the claimant, X-rays, and the medical examination in general, including all his objective and subjective findings. He should give his opinion, not only as to the state of the claimant's present condition, but also as to the cause or effect of an injury or disease; as to whether pain is real or simulated; whether the injury is recent or of long standing; and whether or not it is the result of the accident complained of by the claimant.

Realizing the hardship that is placed upon the doctor in leaving his patients for the purpose of coming into court to testify, we members of the Commission permit and, in fact encourage the submission of the doctors' testimony by written report; however, you should bear in mind that your report, to be of value to the Trial Commissioner, must be in detail as respects the history given by the injured workman, the subjective complaints, your physicial findings, and your opinion as to the disability, be it temporary or permanent. It is necessary, where your report is to be considered in lieu of your testimony, that you be specific as to the amount of disability; that such disability is or is not the result of the injury as related to you by the injured workman; and that the rating of disability if any, is based on the injured workman's condition at the time of your examination and not simply on speculation as to what his condition might be at some future time. To better illustrate the importance of making your reports full and complete, I call attention to the case of Bergstrom Painting Company et al against Pruitt et al, decided by our State Supreme Court on November 6, 1951. There was certain medical testimony upon which the Trial Commissioner relied in making his award. This was: "This man received a soft tissue injury to his lumbar spine as a result of his injury on November 3, 1949 and is, at present, totally, temporarily disabled, which disability will persist for four to six months from this date and he will probably have a permanent partial disability of his back of twenty-five per cent." The Supreme Court found that this medical opinion was too indefinite and uncertain upon which to base an award for permanent disability. Under the testimony of the doctor, the claimant was at the time of

the hearing still temporarily, totally disabled. The healing period had not then ended, and the Supreme Court stated: " . . . in our opinion it was impossible for the doctor at that time to estimate, with any degree of accuracy the extent of disability claimant might have six months thereafter. The testimony of the doctor as to the probable extent of permanent, partial disability claimant might eventually sustain as a result of his injury is based solely on speculation, conjecture and surmise, is without probative value and wholly insufficient upon which to base an award of permanent disability." I feel confident that if the doctor had stated that, in his opinion, the claimant had approximately 25 per cent permanent, partial disability to do and perform ordinary manual labor as a result of the accidental injury of November 3, 1949, then in that event it would have been sufficient to sustain the award.

I now come to a matter that has been quite disturbing to members of the Commission for a long time, and it is with reluctance that I touch upon it, as it may cause some embarrassment to some of your profession; but let me assure you that it is not intended in that light, but rather with the intent to be helpful with a view toward either correction or advice. We commissioners have never been able to understand why there should be such a wide divergence between the opinions of the doctors as to the rating of disability. I can understand why there might be a reasonable difference, but I am referring to the numerous cases where the claimant's doctor will estimate total or a high percentage of disability while respondent's doctor will find a very low percentage or no disability. Obviously, one or the other is not being honest; and where we find that the same doctors are repeatedly making such reports or so testifying, it becomes increasingly difficult to lend credence to any of their reports or testimony. In some instances we find it necessary to appoint an impartial medical examiner to evaluate the case. I am pleased to say medical experts I refer to are definitely in the minority, but there are a few in the various localities over the State who have abused their privilege as expert witnesses in testifying before the Commission.

GROIN HERNIA IN INDUSTRY*

F. L. Flack, M.D., F.A.C.S.

Tulsa, Oklahoma

Physicians examining large numbers of industrial employees realize the great frequency of groin hernias. Eighty per cent of all hernias and more than 90 per cent in males are inguinal in location. An analysis of the draft records of World War II disclosed that two per cent of all men examined had ruptures. We are well aware that many employees with hernias are working and doing their work in a satisfactory manner, but could be made safer and better workmen by hernia repair. In view of this information on employees, especially those in heavy industry, what should be our attitude in regard to repair? We must realize that the larger per cent we do not see and they continue with their work. They are afraid to report to the doctor, they are afraid of an operation and afraid of the results, and they have heard many unfavorable statements about rupture operations.

I am certain that it is a fair and reasonable statement that all, or practically all, hernias should be repaired. The great improvements in anesthesia, the pre and after operative care, the skillful use of fluids and electrolytes, and the practice of early ambulation have brought about a set of conditions whereby heart and lung disease, old age and other disabilities are seldom contra-indications to the repair of a hernia. There is danger in neglecting to repair ruptures. Advising a patient with a small hernia not to have it repaired may lead to the necessity of a large hernia repair. When they are small they are simple and the results are highly

*Presented before the Symposium on Industrial Medicine at the Annual Meeting of the Oklahoma State Medical Association, April 15, 1953.

satisfactory. When they become large they are more difficult and the results are not so good. However, to advise a patient even with a large hernia not to have it done may result in strangulation, incarceration, obstruction or an unwieldy mass to carry around. Certainly, it is a great handicap for a workman to carry around a big rupture. Such an employee is not efficient. Emergency surgery of strangulated hernias in old people carries a very high mortality and morbidity. Operation should be performed as an elective procedure before complications develop which make the case hazardous.

We should not tell hernia patients, "Oh Yes! You have a little rupture but lots of people have such things and get along without any trouble and never require an operation." These people should be told in the prime of life, as soon as the diagnosis is made, that they should, as quickly as reasonably possible, be operated. Another bad thing is to tell them to get a truss, just as though all that was necessary was to go to the drug store and ask someone working there to hand down a truss. Very few know how to fit a truss. Most assuredly I do not. Such statements about a truss might well have been made 50 years ago when the operations of Bassini and Halstead were being developed and perfected.

One of the strongest arguments against a hernia operation is that it does not guarantee a cure. Of course, a doctor of medicine cannot guarantee a hernia operation to cure, but he certainly can explain that a very small percentage of recurrences take place and can say that the longer the operation is put off the greater the dangers and the less likelihood of a cure. The attitude of neglect in hernia cases is not to be condoned. The same line of reasoning applies to recurrent hernias. Naturally, the percentage of recurrences after an operation for a rupture that has been repaired, one or more times, is greater, but the insistence on their repair should also be greater. A recurrent hernia under the Oklahoma State Workmen's Compensation Act is an expensive matter.

THE MEANING OF LARGE INGUINAL RINGS

In the examination for employment, applicants are examined for hernias and the question must also be answered as to the condition of the inguinal rings. The implications seems to be that large or relaxed inguinal rings predispose to hernias and that a big ring is a potential hernia. Many years ago when I examined a man for employment as a pumper or roustabout or roughneck and felt a large ring, my opinion was that a hernia would soon come down. However, I have examined many thousands of such cases and have been able to secure adequate follow-up observations down through the years. To my surprise very few, and as a matter of fact no greater per cent than those with small rings, developed a hernia. I feel that the significance of a large or relaxed inguinal ring is of very little consequence. I do not reject an applicant on account of large rings. There certainly is marked disagreement as to what makes a large or a relaxed ring. All kinds of funny measurements are offered, such as admitting an index finger, twice the size of an adult middle finger, admitting freely the tip of the little finger are used. Nothing is said about the standard size of a little finger or a middle finger, or whose index or little finger. Surely, there is a great variation in size. My test, which is not very accurate, says a ring is relaxed if it freely admits an average index finger which is three-fourths of an inch in diameter across the end, and if there is also a decreased muscle tone.

The matter of relaxed inguinal rings is a personal equation factor. I have estimated that ten per cent of the men I have examined for oil field work have had this condition present. I have had the further advantage of being able to follow these cases for many years and to secure excellent records. If one of them develops a hernia you may be certain I will know about it. The age group has been between 20 and 40 years and most of them were applicants for work in the oil field. More than 50 per cent had bilateral relaxations. My impression is that relaxed subcutaneous inguinal rings are of no great significance in regards to a hernia developing later. I realize that it has been stated that persons with relaxed subcutaneous inguinal rings are twice as apt to develop a hernia in subsequent years. Also, good examiners and observers do not feel that relaxed rings predispose to the development of an inguinal hernia at a later date.

PRINCIPLES OF HERNIA REPAIR

Assuredly, I do not intend to give the technique of a Bassini or Halstead operation or discuss the McVay or Cooper's procedure or the Lotheissen stitch. Everyone is familiar with those procedures. Every hernia we do, we should try to do better than the previous

one. The principles of hernia repair, after the sac has been carefully and cleanly dissected up to the internal ring and closed, are questions of wound healing. It is fibrous tissue alone that produces union. Any fat bearing tissue prevents healing because fibrin bundles cannot form in the presence of fat. Muscle fibers do not heal, but the connective tissue in muscle fibers heals and heals well. The perimysium and endomysium are connective tissue and unite firmly when properly traumatized. My experience in operating recurrent hernias is that one invariably finds the internal oblique muscle united to Poupart's ligament where no fat intervenes and the sutures have been tied tightly. If you want to secure union between the conjoined tendon, internal oblique muscle and Poupart's ligament, the sutures must be tied snugly even up to the point of strangulation. It is first necessary to see that fat bearing tisue does not come between the muscle and the ligament. The sutures must be tied tight enough to traumatize and strangulate the muscle so that a connective tissue reaction is produced. This traumatic reaction starts the fibrous formation that results in fibrous tissue which makes the union. Many years ago I repeatedly looked at the slides and read Hertzler's work [1] on wound healing. In substance he states, "Fibrin begins to form within a few hours after the ligatures are placed and is complete in about three weeks. This is truly a fibrosing myositis, the reaction being due to the injured muscle. The pathological picture is that of a mild chemical inflammation. The cellular changes are identical. The leukocytes predominate at first to be succeeded by round and endotheloid cells. It is the same as seen in fibrosing myositis due to a crushing blow to a muscle as one sees a few days after an injury to the thigh." It is contended that catgut is not good because it produces a reaction. Well, that is just exactly what is desired. Silk, linen, cotton, etc., do not produce union in a poorly done hernia repair and should not be expected to do so, and strips of fascia lata only save the price of a tube of catgut and make big knots and lumps. Also, a hernia repaired with silk or other non-absorbable sutures where the two branches of the anterior ramus of the first lumbar nerve; namely, the ilio-hypogastric and the ilio-inguinal are cut or tied or the anterior branch of the twelfth thoracic is cut or tied is not superior to one with catgut. It is to be remembered that these nerves, in addition to supplying the lower abdominal muscles, have several sensory branches. For many years, following the lead no doubt of many surgeons before me, I have placed two rows of sutures uniting the conjoined tendon and oblique muscle to Cooper's ligament and the inguinal ligament. The first row unites the conjoined tendon and the internal oblique to Cooper's ligament very tight and as a matter of fact just short of cutting through. This excites the fibrosing myositis reaction. A second row of chromic catgut sutures starts just back of the first and is drawn not so tight so as to produce a lesser reaction. Both rows of sutures are placed beneath the cord. This produces a wide area of scar tissue extending into the adjacent muscle. No fear of sloughing must need be entertained. After three weeks and for many weeks following, a broad area, even as much as 5 cms. in extent can be felt at the site of the incision. This is a valuable finding and means that a good union over a wide area is being obtained.

Often this area of palpable thickening and and induration persist for many months and is evidence, of course, of healing.

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Meet Our Contributors

A guest speaker, *Judge Tom Hieronymus*, has a paper in this issue of the *Journal* on "Evaluating Medical Testimony." Judge Hieronymus is chairman of the Oklahoma Industrial Commission.

F. L. Flack, M.D., chief surgeon for the Sinclair Oil Company, Tulsa, wrote the paper on "Groin Hernias in Industry." Doctor Flack, who was graduated from the University of Kansas School of Medicine in 1912, has been certified by the American Board of Surgery, is a fellow of The American College of Surgeons and a member of Southwestern Surgical Congress.

Kieffer Davis, M.D., industrial physician affiliated with the Phillips Petroleum Company, Bartlesville, is another physician appearing on the "Industrial Medicine Symposium" at the Annual Meeting, who has a paper in this issue. Doctor Davis wrote "The Relation of the Private Physician to Industry." Doctor Davis was graduated from the University of Louisville School of Medicine in 1938 and is a member of several medical organizations including the American Association of Industrial Physicians and Surgeons.

RELATION OF THE PRIVATE PHYSICIAN TO INDUSTRY*

Kieffer Davis, M.D.

Bartlesville, Oklahoma

With the advent of rapid influx and growth of industry in Oklahoma and our neighboring states the need becomes apparent for the development and advancement of basic medical relations to this expanding way of life. In the past, industry has existed on a relatively lesser scale in our part of the country and subsequently has been looked upon as a necessary inconsequential thing that had to be tolerated. The connected medical problems were, in many instances, cared for in a back seat, lackadaisical manner. Today it is imperative that we realize the fallacy of this attitude of indifference for over 75 per cent of our working population is employed in industry. The American Academy of General Practice, from a survey of its membership, records that 94 per cent of its members with a nationwide distribution see industrial cases, and that an average number of cases so seen in a recent year was 234 per member. This, however, does not mark these practitioners as industrial physicians, but rather means that almost every practicing physician has some share in industrial medicine. Hence, it is my belief that the time is at hand for those of us who are full-time or part-time industrial physicians to consult with you in general practice and other specialties concerning our problems and the basis of association that will best benefit all.

Medical progress in industry is of vital interest to the employer, the employee, the physician and the community. It has long been recognized that the health of our employed population is important if the human resources of the country are to be fully utilized for efficient production and full employment. For this reason it has become necessary to expand the primary aims of industrial medicine, from care of on-the-job injuries and pre-employment examinations, to include such principles as anticipation and prevention of diseases and the building of greater health in the employee masses. Although infectious diseases and industrial injuries are presently at a new low, other conditions arising out of environmental contacts are detrimental to the health of man. Environments of man which used to change slowly through the ages are now changing practically over night because of new machines and products of such advancing industries as chemical, plastic, petroleum, automotive, airplane, etc. As a result many new problems have been created and are being created today—i.e. exposure to radioactive materials, contact or occupational dermatitis, silicosis, toxicological problems from certain chemical exposures, air pollution, stream pollution, etc. Thus, the field of industrial medicine is expanding from its interests of a few years ago, when it was confined to curative medicine and simple problems in the plant, to medical problems involving all individuals in society. In industry, preventive, educational, constructive and company health coordination practices are in general the responsibility of the full-time industrial physician; the curative aspects are, in the main, cared for by the private practitioners. It is commonly accepted that both phases of practice are essential to a well organized health program in industry. Optimum health of the worker can be maintained only through complete understanding and willing cooperation between the industrial physician (the medical director or plant physician) and the private physician.

Little more than one per cent of all workers are physically fit for all types of work. This means that the great mass of the working population is limited to some degree. Consequently, the pre-employment or preplacement examination has always been one of the most important services in industrial medicine. Because of new and powerful pressures arising from within as well as outside of industry this placement examination is all the more necesary today. Placement may be called the process of adjusting the worker

*Presented before the Symposium on Industrial Medicine at the Annual Meeting of the Oklahoma State Medical Association, April 15, 1953.

to the job that will afford the best use of his skills and agree with him physically. The goal of a good placement program is to have each worker healthy, happy and secure in his job, home and community. It is needless to say that a happy employee means reduced injury rates, less absenteeism and greater productivity. Many of you are doing a very good job today in helping industries place new employees. The best results, however, cannot be expected unless the examining physician has a knowledge of specific job requirements and physical demands of each respective job classifications in an industry. To the average private practitioner this is apt to remain a mystery until such time that he visits the industry and develops this information from talking to the plant physician and superintendent and actually watching the worker at his job.

Only approximately eight-ten per cent of industrial medical and surgical work done today can be classified as curative. This percentage represents the cases of on-the-job diseases and injuries and the resulting subsequent absenteeism. These figures are not stated to minimize the importance of the injured employee, but rather to demonstrate the amount of absenteeism existing in industry today from reasons other than occupational diseases and injuries. And too, these figures reveal to the practicing physician that his obligation to industry should not begin or end with the suturing of a laceration or the casting of a Potts fracture sustained on the job.

In today's hustle-bustle life it is not altogether unreal that things of seemingly lesser importance are passed over hurriedly in the old "lick and a promise" way. Let this not be true in any industrial injury case brought to you for care. In a serious mishap when the emergent or immediate care, which is occasionally heroic and life-saving, is completed, time is well spent when the patient is examined for possible pre-existing physical conditions and other unmanifested factors related to the injury. It is not unusual that additional findings will be brought to light which may influence the treatment and be effective in the healing period and even the extent of recovery of the injured man. Complete history of the accident and first-aid care can usually be obtained from the plant safety or personnel man or nurse accompanying the injured man to your office or hospital. Such information as the immediate and associated causes of the injury, lapse of time since accident, possible exposures to physical and chemical agents, etc., can also be of invaluable aid. A true evaluation of the case can be made only after all of these factors are known.

As a matter of interest, every 35 minutes a worker dies in the United States and 120 are injured from on-the-job accidents. The National Safety Council reports that 15,000 persons were killed in occupational accidents in 1952 and approximately 2,000,000 were injured. The cost of these accidents was roughly $900,000,000 in wage losses, $200,000,000 in medical expense and $250,000,000 overhead cost of handling the insurance. The indirect cost, that is, damage to equipment and materials, production delays and time lost by other workers who stop working or slow down at time of accident, was approximately $1,300,000,000. The estimated total economic loss, therefore, from occupational accidents in 1952 was $2,650,000,000.

Many of you realize that the man who sustains an injury in industry usually requires a longer healing period than does the individual having a similar injury at home. Factors such as feeling of job insecurity, depression from breaking perfect safety records, economic instability, etc., are reasons for this delay in recovery. Consequently in severe cases it is necessary to begin rehabilitative work immediately. In the early stages this means not only that the patient should have the best hospitalization and the best specialty care, but also that he be convinced that these things are in effect. He must be treated optimistically. He should be told of his injury, but not in a manner that may be frightening or arouse suspicion. He must be treated as a "whole man" while treating him separately. The time for dehospitalization must be elected wisely as well as the time of return to work. It is needless to say that we have all been guilty of mishandling this phase of an injured man's rehabilitation. However, as long as we develop our opinions on these matters scientifically, logically and sincerely, and not by "guestimations" the chances of erring will be held to a minimum. In some instances the injured will rehabilitate more quickly when he is permitted to return to some type of restricted work. Others, particularly those who are malingers or have malingering ten-

dencies — commonly known as "greenbackitis"—never apparently complete their healing phase. In any event, all industrial cases reach termination; the great majority through excellent handling of the attending physician, return to work with no disability and with a minimum of absenteeism; others are returned to work only after disability has been evaluated and settlements eventuated either individually or through the State Industrial Commission. Evaluation of disability is just as much the responsibility of the practicing physician as is the actual medical or surgical care of the injured man.

The insurance carrier is too often looked upon as the pot of gold at the end of the rainbow; the middle man who has no interest except that of paying big medical and surgical fees for which a large percentage handling charge is made. These ideas are not up to date. Even though the insurance carrier may at times apparently be a disinterested third party or an innocent bystander, and one who adjusts claims, his responsibility to both the employer and the State Industrial Commission is such that his relation with employee and employer must at all times be above board and beyond reproach in order to maintain integrity and standing. The insurance carrier's ability to function satisfactorily and to the agreement of everyone involved depends to a great extent upon the cooperative efforts of the attending physician. These efforts or legal obligations, as they may be looked upon, consist of:

1. Notify medical director or other representative of management and insurance carrier of seriousness of injury and of necessary specialty care.
2. Submission of physician's first report as early as possible after injury occurs.
3. Progress or interval reports in prolonged cases.
4. Final report when patient is released from further medical care. Included should be statements concerning whether or not the healing period is complete and the estimated amount, if any, of disability.

Many practicing physicians have looked upon these obligations to the insurance carrier as the "necessary evil" or unpleasant work connected with industrial or compensation cases. This impression, fortunately, is fading into the background, for being creatures of habit, we are accepting this as a matter of routine in today's role of medical practice.

Today's increased tempo of living along with mechanization of industry in its attempt to meet the great production demand of both peace and war are creating new problems that heretofore did not exist very much in our population at large and especially in those connected with industry. Many workers who through necessity must be geared to high speed and work under increasing pressures and tensions are showing evidence of fatigue and nervous disorders. It matters little, however, whether or not these troubles are directly or indirectly connected with the employee's job for full weight of the burden usually falls on the employer. From 1,500,000 to 2,000,000 workers are absent daily because of sickness and it is estimated that one-third of this absenteeism is unnecessary. Sickness benefit and unavoidable absenteeism plans commonly existing in industries which pay equal and occasionally more than regular pay often stimulate the employee to take undue advantage of the employer's faith and trust. At times the practicing physician may knowingly or unknowingly be a party to this unnecessary absenteeism by signing certificates of illness for an employee returning to work without having sufficient knowledge of the supposed case.

The standard 40-hour working week means that only 25 per cent of the employee's time is spent on the job. Many things can happen to him health-wise while he is away from work. In attending these persons it behooves all of us to evaluate more carefully the emotion or psychic factors involved in every case of illness or disability. We see many cases that have been treated for some organic disease when actually the illness was on an emotional basis. For example: A 46-year-old male employee used to visit my office at least twice a day for antiacid medications from the nurse. This had been going on for some time before it was brought to my attention. Questioning revealed that he had had a sour stomach, dyspepsia, fatigue and other vague G.I. troubles for many months. His family doctor had x-rayed him and found nothing. He had been examined repeatedly by gastro-enterologists. Many varied medications had been taken but to no avail. After much time was spent gaining this man's confidence it was learned that he had been working for over 15 years at an office job he despised. It was then relatively easy to find out that he enjoyed the outdoors for all of his spare time was spent in hunting, fishing, camping, etc. Fortunately, at

our recommendation, his department was able to transfer him to a field job. His trouble subsided practically over night.

Let us approach this type of case, as well as the problem drinker and others who report to work with the "Monday morning blues", from a psychosomatic aspect.

Industry has made startling advances during the past few years in the technological aspects of mass production. Man will be able to keep astride of these advances only if adequate attention is given to his psychological stresses. The private physician by reason of his close relationship to the worker, who is his patient, is in an excellent position to stimulate the individual to seek optimum health.

These are some of the problems that will be a challenge if you expect to keep abreast of occupational medicine as it is advancing today. Attention to these things constute your duty not only to the employee of industry, but to the employer as well.

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S. M. A. AUXILIARY PLANNING STREAMLINED CONVENTION

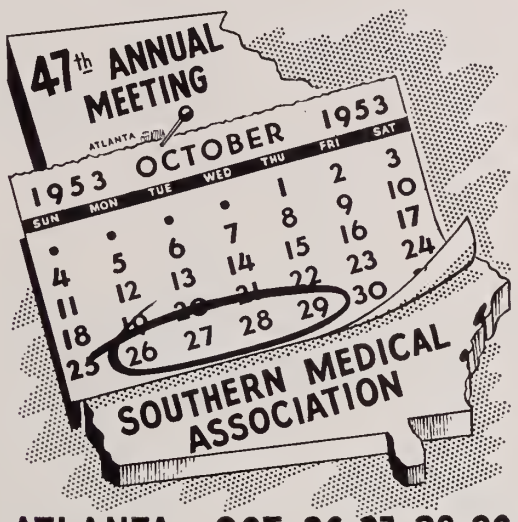
Mrs. Richard F. Stover, President of the Woman's Auxiliary to the Southern Medical Association, has announced that the convention to be held in Atlanta, Georgia, October 26-29, will be streamlined so that time may be given to the members for shopping, being with their husbands and visiting with friends.

All regular meetings of the Auxiliary will be held at the Henry Grady Hotel, where there will, also, be a registration booth; another registration booth and exhibits will be at the Municipal Auditorium. Meetings are planned as follows: Tuesday 10 a.m. to 12 noon, Wednesday 10 a.m. to 11:30 a.m.

Mrs. Leo J. Schaefer, President of the Woman's Auxiliary to the American Medical Association, will be guest speaker and Mrs. Stanley A. Hill, Corinth, Mississippi, will be installed as president at the Wednesday morning meeting.

A Research and Romance of Medicine luncheon or tea will be held on Tuesday. Dr. Frank G. Slaughter, famous surgeon and novelist will be the guest speaker. A Doctor's Day Luncheon honoring two "Doctors of the Year from the South," Dr. William L. Pressly, Due West, S. C. and Dr. N. M. Travis, Jacksonville, Texas, will be held at the Atlanta Athletic Club on Wednesday at 12:15 p.m. All auxiliary members and their husbands are invited.

If you have not already done so, we suggest that you make your hotel reservations now. Address your request for reservations as follows: Bureau of Housing, Southern Medical Association, 801 Rhodes-Harvey Building, Atlanta 3, Georgia.



ATLANTA, OCT. 26·27·28·29

For the fourth time in its history, the Southern Medical Association will meet in Atlanta, Georgia.

Physicians of the South are urged to mark the dates of this meeting an their colendors and moke every effort ta attend this autstonding meeting of the yeor.

In oddition to the forty-seven holf-doy sectian meetings covering every ospect of the medicol proctice, there will be o generol sessian, conjaint meetings, many social octivities, and fraternol and alumni gotherings—a complete general medicol meeting, with all scientific activities under one roof, the Atlanta Municipal Auditorium.

Hotel occommodations for this meeting moy be secured by writing: Housing Bureau, Southern Medical Association, 801 Rhodes-Haverty Building, Atlanta, Georgia, giving hotel preference, type of accommodations desired, date and haur of arrival and deporture, name ond address.

While membership in the Association is not a requirement for attendance at the annual meeting, it affords many advantages, among which is the Sauthern Medical Journal, one of the leading publications of today. Membership dues including the Jaurnal ore only $10.00 per yeor. There is no registrotion fee ot the annual meeting.

Members of state and caunty medical societies for membership are invited ta became members of the Association and attend the Atlanta Meeting, which promises to be ane af the most successful meetings ever held by the Sauthern Medical Assaciatian.

SOUTHERN
MEDICAL ASSOCIATION

Empire Building
Birmingham, Alabama

President's Page

On October 4, I was privileged as President of the Association, to be present at the formal dedication of the new Veterans Administration Hospital in Oklahoma City.

During the dedicatory activities, I experienced mixed eomtions concerning this federal government facility for the care of veterans.

Here on one hand was a 500 bed hospital, modern in every respect, staffed by full time physicians with the finest of the medical profession's physicians in Oklahoma City on its consulting staff ready to render the finest hospital and medical care possible to veterans. This entire medical facility stands as a permanent monument to not only the advancement of medical science and care for the veteran, but the extent to which our government has accepted its responsibility for veterans' care.

On the other hand, I could not help but reflect upon the cost to the taxpayers of the care that is being rendered in veterans hospitals to persons who are receiving it for conditions that were in no way attributable to service to their country. Mr. Harvey V. Higley, director of the Veterans Administration, in his dedicatory remarks, set aside the veterans as a special kind of citizen. I am wondering how many veterans appreciate this category and whether or not in retrospect it is a compliment or a stigma.

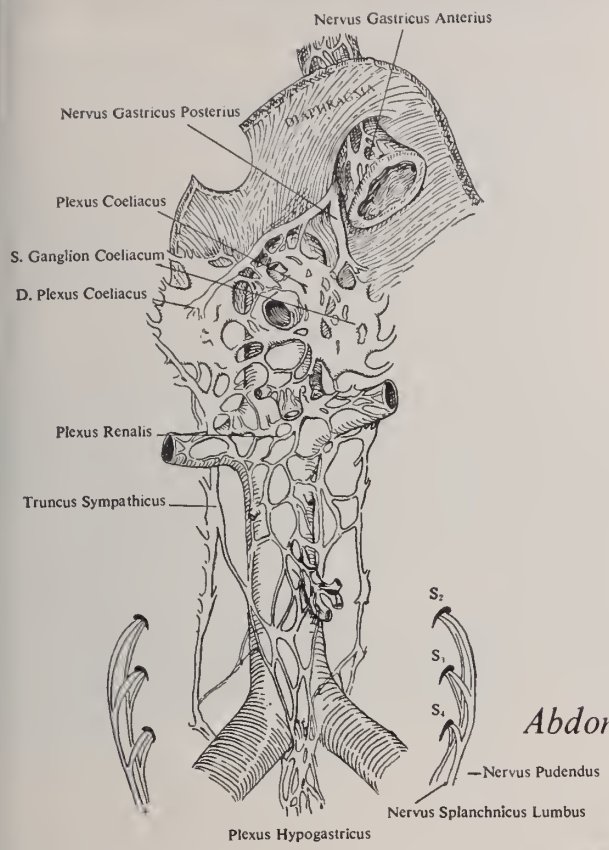
The care of veterans in federal facilities is a problem that must be faced with reality, forthrightness and fairness to both the veteran and John Q. Public, who is paying the bill. It is doubtful if anyone would or could successfully oppose the policy of our government to care for the veteran, who, in any military duty, either large or small, suffered a disability from military service. But, is it fair to the taxpayer to pay out his hard earned money for medical and hospital care to any person wherein his disability may be self secured.

While medicine is awake to this problem, due to its close proximity in the veterans care program, it is not solely the problem of the profession. It is the problem of the American people. As physicians go about their daily lives, they should be certain that when this problem is discussed, as it is likely to be in the future, that the position of organized medicine be made definitely clear. This position in simple words is that we believe the veteran with non service connected disability should pay his own way unless he is truly indigent.

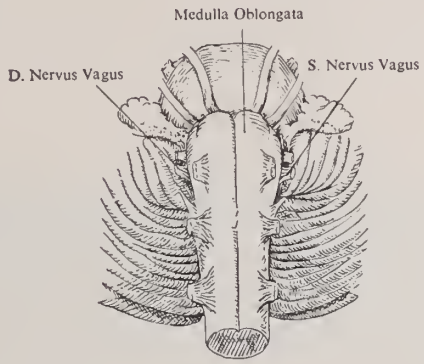
Think this problem over, discuss it and seek to acquaint yourselves with the situation so that the medical profession will not be misunderstood in its attitude.

John E McDonald MD.

President



Central origin of the vagus nerves (parasympathetic)



Abdominal autonomic plexus (sympathetic)

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Banthine® (brand of methantheline bromide) is supplied in: Banthine ampuls, 50 mg.—Banthine tablets, 50 mg.

It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

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SEARLE Research in the Service of Medicine

APPEARS ON TV

Representing the Auxiliary Nurse Loan Fund, Mrs. James F. McMurry appeared on WKY-TV August 19, She was featured on Prissy Thomas' "Guest Room" program. Mrs. McMurry is a former president of the Woman's Auxiliary. Additional publicity has been given the Nurse Loan Fund by Edith Johnson, *Daily Oklahoman* columnist, and the *Farmer-Stockman*. At the present time the Auxiliary is urging applications for the loans.

OSMA REPRESENTED AT PR CONFERENCE

Six representatives of the Oklahoma State Medical Association attended the 1953 Medical Public Relations Institute sponsored by the A.M.A. in Chicago September 2-3. Those attending were John E. McDonald, M.D., O.S.M.A. President, Tulsa; R. Q. Goodwin, M.D., Oklahoma City; Jack Spears, Executive Secretary of the Tulsa County Medical Society; Hugh Perry, M.D., Tulsa; Dick Graham, Executive Secretary, and Mrs. Neil W. Woodward, Oklahoma City, Mrs. Woodward was on the program and headed the panel on how to enlist society support for the Woman's Auxiliary.

The program included a morning session devoted to various aspects of television as applied to medical public relations programs. The afternoon of the first day was given over to six clinics, covering such subjects as television and production techniques as best adapted to medical shows, successful PR programs from a PR standpoint, cultists and quacks and how to combat them, press coverage at state medical meetings, etc.

The second day's program covered problems relating to health insurance, health forums sponsored in cooperation with newspapers, health columnists, and case histories of how best to tell medicine's constructive and positive story to the public.

CONSTRUCTION STARTED ON IDABEL HOSPITAL

Construction of a new general hospital at Idabel began August 1, 1953. The McCurtain County Hospital will be owned and operated by the county, and will have a 24 bed normal capacity and will be completely air conditioned. Total cost of the project will be $310,000. The hospital is scheduled for completion August 1, 1954.

CARDIAC CLINIC OPENS

Announcement has been made of the opening of the University Hospital, Oklahoma City, Cardiac Clinic for indigent patients by Robert H. Bayley, M.D., director of the clinic.

The clinic will operate on Tuesday and Thursday afternoons. Physicians throughout the state who would like to refer patients to the clinic should do so by addressing the communication to the University Hospital Cardiac Clinic or by calling Oklahoma City RE 6-1511, Ext. 202 (Cardiac Clinic secretary). Patients are seen by appointment only.

FROM THE OKLAHOMA DIVISION— AMERICAN CANCER SOCIETY

THE ATLAS OF TUMOR PATHOLOGY

The *Atlas of Tumor Pathology*, being published currently by the Armed Forces Institute of Pathology, is generally credited with being one of the finest publications of this type ever produced.

Many physicians specializing in fields other than pathology have inquired where the fascicles may be purchased. For the information of those interested, we are listing below all fascicles published to date and the American Cancer Society address from which they may be ordered:

FASCICLES OF THE ATLAS OF TUMOR PATHOLOGY PUBLISHED AS OF AUGUST 31, 1953

Fascicle No.	Title and Author	Price
6	Tumors of the Peripheral Nervous System by Arthur Purdy Stout	$ .60
9	Teratomas by Rupert A. Willis	.50
15	Tumors of the Parathyroid Glands by Benjamin Castleman	.65
16	Tumors of the Carotid Body and Related Structures (Chemoreceptor System) by Philip M. LeCompte	.45
17	Tumors of the Lower Respiratory Tract by Averill A. Liebow	1.25
18	Tumors of the Mediastinum by Hans Schlumberger	.75
29	Tumors of the Adrenal by Howard T. Karsner	1.00
31b & 32	Tumors of the Male Sex Organs by Robert A. Moore and Frank J. Dixon	1.50
34	Tumors of the Breast by Fred W. Stewart	1.10
35 & 37	Tumors of the Central Nervous System by James W. Kernohan and George Sayre	.90
14	Tumors of the Thyroid Gland by Shields Warren and William A. Meissmen	1.75

ATTEND LONDON CONFERENCE

Clinton Gallaher, M.D., Shawnee, Secretary of the Board of Medical Examiners, attended the First World Conference on Medical Education at London, England, held under the auspices of the World Medical Asscoiation in collaboration with the World Health Organization, Council for International Organizations of the Medical Sciences and the International Association of Universities. The meeting was held August 22-29. Mrs. Gallaher accompanied Doctor Gallaher and they spent some time in Paris also before returning to the States.

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"The resistant cases showed remarkable response."[1]
". . . has cured where all other antibiotics have failed."[2]

"Patients with pyelitis were well and doing their usual duties within 24 hours . . ."[3]

"Morbidity from apparent genito-urinary causes was noted in only one patient of 44 patients who received prophylactic Terramycin."[3]

"Terramycin is generally well tolerated, the percentage of relapses being low and the percentage of bacteriological as well as clinical cures high."[2]

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DIVISION, CHAS. PFIZER & CO., INC

HAVE YOU HEARD?

John E. McDonald, M.D., O.S.M.A. President, recently addressed the Bartlesville Rotary Club. He pointed out that the medical profession is in serious need of more doctors and better equipped and larger medical schools.

Edgar Nickell, M.D., Davenport, was honored with a community wide celebration August 17 celebrating his birthday and 42 years of medical practice.

William A. Vint, M.D., recent graduate of the University of Oklahoma School of Medicine, has opened his offices in Pryor.

Ralph Simon, M.D. and *Floyd Simon, M.D.*, Clinton, have recently opened a new clinic. The modern structure was built at a cost of approximately $75,000. It is completely air conditioned.

John Moore, M.D., has joined the staff of the Lindsey-Johnson Clinic in Pauls Valley. Doctor Moore served as a preceptorship student in Lindsey in 1951.

L. W. Ghormley, M.D., a graduate of the University of Tennessee College of Medicine, has joined the Osler Clinic in Blackwell. Doctor Ghormley is the son of one of the founders of the clinic, *J. G. Ghormley, M.D.*

Peter E. Russo, M.D., Oklahoma City, attended the Rocky Mountain Radiological meeting in Denver in September.

RELEASED FROM SERVICE

Oklahoma physicians released from service are:

Donald G. Clements (Capt) Tinker Air Force Base, Oklahoma City, released June 30, 1953. Current address not available.

Robert D. Anspaugh (Capt) Fort Campbell, Kentucky, released August 7, 1953, now practicing in Oklahoma City.

Edward P. Shanks (Lt. j. g.), from navy, now practicing at 610 South Monroe, Enid.

ON ACTIVE DUTY

Physicians from Oklahoma who recently went on active duty are:

Fred Mac Long (Lt), Oklahoma City, entered service July 5, 1953. Stationed at Fort Sam Houston, Texas.

Samuel J. McDaniel (Lt), Oklahoma City, entered service August 4, 1953, stationed at Fort Sam Houston, Texas.

John Howard Morledge (Lt), Oklahoma City, on active duty with the U. S. Air Force July 12, 1953.

M. Jorge Torres (Lt), Oklahoma City, entered service August 4, 1953, and now stationed at Fort Sam Houston, Texas.

HEART ASSN. DATES CHANGED

The 27th Scientific Sessions of the American Heart Association will *not* be held at the usual time in 1954, but will take place following the 2nd International Congress of Cardiology in September. The International Congress of Cardiology will be held in *Washington, D.C.*, September 12 through 15, 1954 and the Scientific Sessions of the American Heart Association will also be held in Washington, September 16 through 19.

OBITUARIES

PAULINE BARKER, M.D.
1887-1953

Pauline Barker, M.D., long time Guthrie resident and first woman graduate of the University of Oklahoma School of Medicine, died August 21.

Doctor Barker, whose specialty was EENT, was born in Larkin, Kansas, and came to Oklahoma when she was a child. She taught school at Cashion before graduating from medical school in 1912. Following graduation, she came to Guthrie to join her brother, the late J. L. Houseworth, M.D., in the practice of medicine.

Doctor Barker's husband, C. B. Barker, M.D., preceded her in death in 1939. Survivors include two sisters.

L. E. GEE, M.D.
1878-1953

L. E. Gee, M.D., Broken Bow physician, died July 15. Doctor Gee was born June 24, 1878 in Gladewater, Texas. He received his degree in 1901 from Memphis College of Medicine and practiced in Wade, I. T., Caney and Texas before coming to Broken Bow.

Doctor Gee was presented a 50 Year Pin in the O.S.M.A. in 1950. He had served as both President and Secretary of his county medical society.

L. E. JACOBS, M.D.
1885-1953

L. E. Jacobs, M.D., long time resident of Hanna, died August 11 in a Henryetta hospital.

Survivors include two daughters, two sons and three sisters.

Burial was in Clarksburg, Arkansas.

HEALTH DEPARTMENT NOW LICENSING REST HOMES

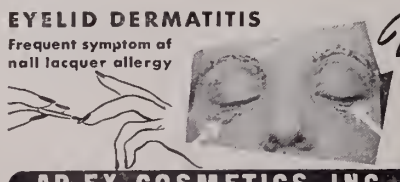
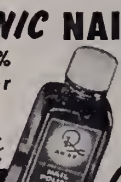
Recent legislation (Senate Bill 325) places the responsibility for administering a licensing program for rest homes and nursing homes under a single agency, the State Department of Health.

The licensing program for the rest homes was formerly conducted by the State Department of Public Welfare. At the present time, there are 67 rest homes, 39 related institutions, and 194 nursing homes in Oklahoma.

The Hospital Division of the State Department of Health will work actively on the licensure program, although the program will be separate and distinct from hospitals and related facilities. The legislature directly appropriated $70,000 for the biennium to implement the provisions of the Act.

The Act should make possible a single set of standards and drastically reduce administrative problems. It will extend jurisdiction to all rest homes and nursing homes regardless of size and type.

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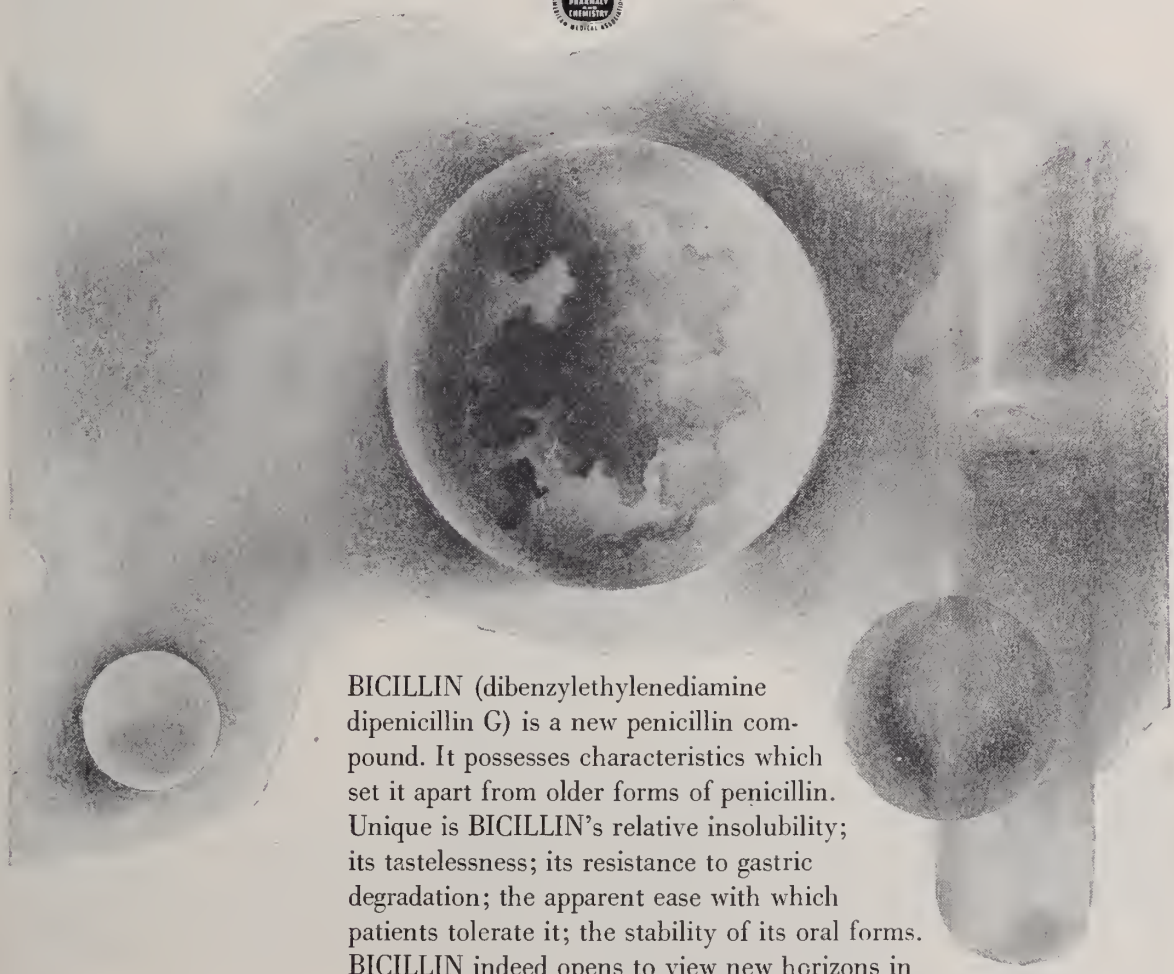
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Announcements

SOUTHERN MEDICAL ASSOCIATION. Atlanta, Georgia, October 26-29.

OKLAHOMA STATE HOSPITAL ASSOCIATION. Tulsa, Mayo Hotel, November 10-13.

A.M.A. INTERIM SESSION. St. Louis, December 1-4.

OKLAHOMA ACADEMY OF GENERAL PRACTICE. Tulsa, Tulsa Hotel, February 15-16, 1954.

OKLAHOMA STATE MEDICAL ASSOCIATION. Oklahoma City, Municipal Auditorium, Oklahoma City, May 10-11-12, 1954.

AMERICAN UROLOGICAL ASSOCIATION. New York City, Waldorf-Astoria, May 31—June 3, 1954. For further information concerning the meeting and the essay award write the Executive Secretary, William P. Didusch, 1120 North Charles Street, Baltimore, Maryland. All essays must be in his hands by February 1, 1954.

Book Review

SCIENTIFIC PRINCIPLES IN NURSING. Esther McClain, R.N., M.S. 410 pages. Illustrated. C. V. Mosby Company., St. Louis, 1953. Second Edition. $3.50.

Several definitions of nursing are summarized to develop the premise that nursing is a science and an art. With this in mind, the book outlines various basic principles clearly. An example: "The nurse works by precept and example to educate patients in laws of hygiene and sanitation that health regained may be health retained. She teaches indirectly by her attitudes and the type of nursing care she gives."

Each chapter includes the principles of related courses in dealing with the nursing procedures, as well as learning situations for the patient, and a check list for judging nursing practice.

This book is readable and useful. —Pansy Nigh, R.N.

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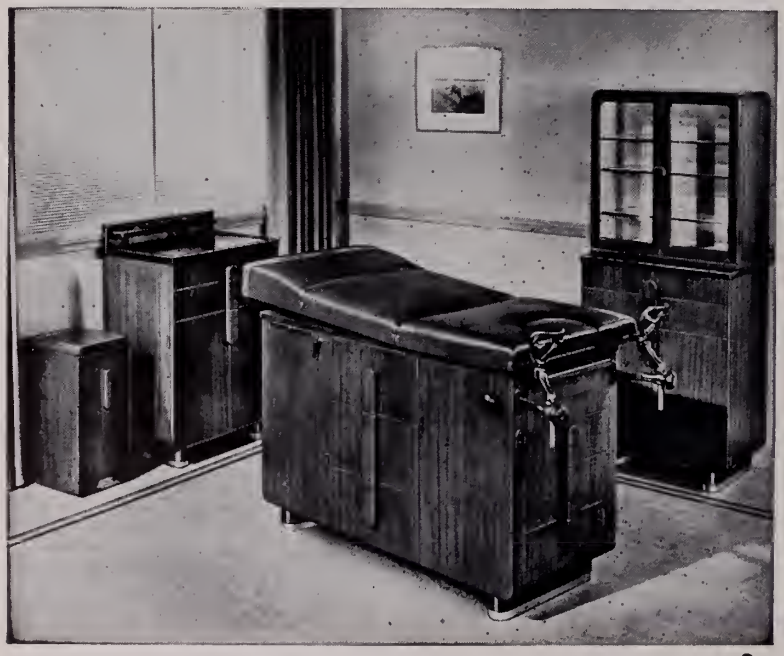
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OCTOBER 26, 27, 28, 29, 1953

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MURRAY M. COPELAND, M.D., *SURGERY*, Professor of Oncology, Georgetown University Medical Center, Washington, D.C.

CHARLES C. DENNIE, M.D., *DERMATOLOGY*, Professor of Dermatology, University of Kansas Medical School, Kansas City, Missouri.

WILLIAM S. FIELDS, M.D., *NEUROLOGY*, Professor of Neurology, Baylor University College of Medicine, Houston, Texas.

ERLE HENRIKSEN, M.D., *GYNECOLOGY*, Clinical Professor of Gynecology, University, University of Southern California Medical School, Los Angeles, California.

W. PAUL HOLBROOK, M.D., *MEDICINE*, Director of Research, Southwestern Clinic and Research Institute, Inc., Tucson, Arizona.

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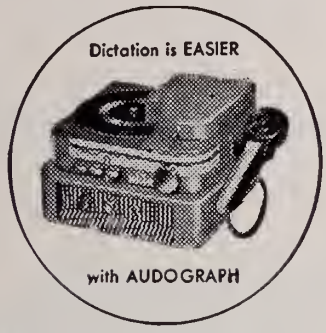
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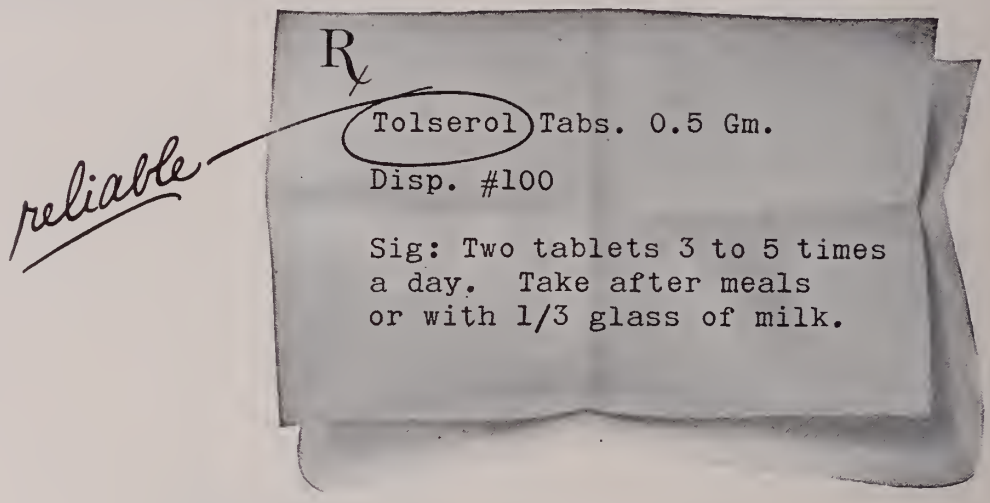


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EDITORIALS

MEDICAL EDUCATION

The first world conference of Medical Education met in London August 22-29, 1953.

Our own Dr. Clint Gallaher was in attendance and can give a good account of the sessions he attended. The best and most complete reporting I have seen on the meeting is in the August 29 *British Medical Journal* and the two or three succeeding issues. To give our readers a tempting taste of this memorable meeting these paragraphs are quoted from the President's address, "The challenge to medical education in the second half of the twentieth century," by Sir Lionel Whitby, C.V.O., M.D., F.R.C.P., Regius Professor of Physic, University of Cambridge:

"In the meanwhile what likelihood is there that something will be done? That those in control of medical education will really have the humility and courage to admit that all is not at its best in the best of all possible worlds, their worlds? That those who hold the shaping of the future in their hands will fashion it with vision and imagination so as to inspire the young man and woman to pursue the tasks of our great profession with a feeling of dedication to something greater than themselves? There is indeed a likelihood, otherwise so many of us would not have met here in London in the month of August. But the possibilities must be turned into probabilities and certainties, and until this happens we must possess our souls with that discontent that has so aptly been called divine."

The following from "What is Education?" by Sir Richard Livingstone, M.D., Hon. D. Litt., Hon. LL. D., should serve as a further challenge in this puzzling age. After quoting Browning who posed this question as though he were living today, "Whom shall my soul believe?", he said:

"That is a plausible question, but more embarrassing in dialectic than in fact. There is no real doubt that Homer and Shakespeare are great poets, Bach and Beethoven great musicians, Plato and Kant great thinkers, Newton and Faraday great men of science. Even in the more uncertain field of character and conduct no one is likely to doubt that in St. Francis or the Buddha, in Lincoln and Masaryk, we see the first-rate. We are safe in accepting the judgment of time; it is rarely reversed on appeal.

"To repeat, an education which leaves us without a philosophy of life is as incomplete as one which leaves us unable to think or to express our thoughts. And never was a philosophy as necessary as in an age of divided purposes and paralysing doubts about ultimate ends. Our civilization is fluid, its future form still to seek and make. At present it is a curate's egg civilization—some of it excellent, some of it fourth-rate. If you question this criticism, look at our cheap daily papers. Yet ours is an age of great vitality, of unlimited powers and possibilities, too often frittered away or misused. We have the materials of a great civilization: all that is needed is to stamp it with the print of excellence."

To this could be added thought provoking messages from our own John F. Fulton, Sterling Professor of Medicine at Yale who spoke on "History of Medical Education" but space will not permit. This conference has placed the world on the shoulders of medical educators and it is heavy.

MEDICAL WRITING

During the past few years the Editorial Board has been impressed by the obvious improvement in the character and content of the manuscripts received for publication in the Journal. But perfection in scientific writing is rarely attained, consequently, the Board tries to keep the subject of better writing ever in the minds of our readers and prospective contributors. Please note the Special Article by our Editorial Assistant in this issue of the Journal.

OKLAHOMA'S STUDENT AMERICAN MEDICAL ASSOCIATION

Here is a medical organization that should command the full cooperation of all mature, forward looking University of Oklahoma School of Medicine faculty members and the good will of physicians everywhere.

In this Association, medical students are getting the feel of organized medicine six or eight years ahead of their medical forebears. In the immediate past they have been good enough to seek guidance from faculty members in their respective schools. In the light of present socio-economic trends and shifting ideologies it behooves medical leadership to develop a warm sympathetic relationship with the group. Its members are hungry for contact with those who teach and those who should lead them in this formative period. They should have an opportunity to learn first hand the high principles of medical practice and the social aspects of the time honored patient-physician relationship.

Those who doubt the significance of this student movement will be interested to know that already there are 63 active chapters in our medical schools. It is anticipated that eight or 10 will be added during the present school year.

Here is a potentiality freighted with power for good or evil. A few decades will determine its course. If the results are good, much of the credit must go to teachers and leaders; if bad they must bear much of the blame.

To illustrate what has been said, the following panel discussion on general practice as a specialty occurred at the third annual national session of this Association:

Distinguished guest speakers respectively discussed general practice in a large city, general practice in a small town and general practice in a rural community.

The president of our local chapter recently represented his group on the program of the annual meeting of the American Medical Writers' Association in Springfield, Illinois. Many other examples might be cited if space would permit. This is enough to point up our responsibility.

HIGH SOCIAL RATING CARRIES HEAVY RESPONSIBILITY

A public opinion poll at Victoria University College, Wellington, New Zealand, placed the physician's social status above that of all other professions, occupations and trades. This rating carries a great responsibility and emphasizes William Osler's significant statement that in the practice of medicine the heart must be exercised equally with the head.

CONGRATULATIONS "UNIVERSITY OF OKLAHOMA MEDICAL CENTER COMMENTARY"

Judging from the first issue of the new Medical Center *Commentary*, this new publication which will appear quarterly, promises much in the field of public relations. The faculty, the students, the alumni, and many friends of the medical center will find these quarterly reports interesting and informative.

The activities of the Medical School and its affiliates have reached proportions which make it difficult for a single faculty member or a department to keep abreast of progress without concerted methods of communication such as this organ may be able to supply.

In this field the *Commentary* may render valuable services. With the exception of the people whom we serve, what could be more important to physicians than the medical school and its allied agencies.

The editorial staff of the *Journal* of the Oklahoma State Medical Association extends congratulations and best wishes.

COMMENTS ON THE KINSEY REPORT

In this issue of the Journal there is a review of the Kinsey Report. Immediately after it was written, this letter was received from the mother of two fine youngsters, a girl and a boy. It is representative of the attitude of many worthy mothers.

"I have seen the book and think there is no excuse for it. I just hope neither of my children see it, as frankly it is worse than disgusting and certainly not a true picture. At my boy's age, it could be very dangerous when we have spent all of these years teaching him to respect the little girls he runs around with. I can't imagine what his feelings would be. Since it is in every periodical, how can one hide it completely from one's young! I am thoroughly fed up with it and its wide publicity and wonder what we are coming to."

The daughter is engaged to a boy who is now in Korea and she looks forward to a chaste home, love and no doubt motherhood.

Scientific Articles

THE EMOTIONAL ASPECTS OF DIABETES MELLITUS *

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A study of any disease involving the endocrine system should include a consideration of the emotional aspects. There is ample evidence that emotional states influence endocrine function and play a part in certain endocrine disturbances. Diabetes mellitus, a disease of the endocrine system whose course is altered by the emotional state of the affected individual, should be included among the psychosomatic illnesses.

As early as 1911, it was pointed out that emotional stress could produce glycosuria. However, this reaction was transient and attempts to produce diabetes experimentally by prolonged emtional tension were unsuccessful. This fact, reinforced by Joslin's observation that only a few cases of diabetes mellitus were detected in over 40,000 hospital admissions of combat soldiers during World War I, seemed to rule out any connection between emotional stress and the onset of diabetes.

After von Mering and Minkowski demonstrated that the removal of the pancreas in dogs produced diabetes in these animals, new impetus was given to research in the field of diabetes. The relationship of the emotional factors in the course of the disease has received relatively little attention.

In 1939, Daniels, of Columbia University, reviewed the literature for the period from January, 1934, through March, 1939. In this five year period he found that only 23 articles, of over 3,000 on diabetes mellitus listed in the *Quarterly Cumulative Index Medicus*, called attention to the emotional factors. A further review of the literature for a ten year period from 1940 through 1949, in preparation of this paper, showed the same disproportion still existed.

*Presented before the Section on Neurology and Psychiatry at the Annual Meeting of the Oklahoma State Medical Association.

Even though most physicians who treat diabetes are aware of a fluctuation in the course of the disease when the individual is under stress, this was only occasionally mentioned and was not included in discussions of the complications of the disease. This may be because the emotional factors are not fully appreciated or that such considerations are mistakenly thought to be beyond the realm of scientific observation.

A review of some of the physiological mechanisms, through which emotional states may influence and modify this condition, provides abundant evidence that consideration of the emotional aspects is both scientific and important. This relationship between the endocrine system and carbohydrate metabolism is intimate and complex.

PITUITARY GLAND

In 1930, Houssay and Biasotti noted hypophysectomy was followed by marked symptomatic improvement in cases of pancreatic diabetes. This stimulated research on the role of the hypophysis, endocrine glands and the nervous system in carbohydrate metabolism.

Young was able to produce a permanent diabetic condition in dogs by injecting large amounts of extracts from the anterior lobe of the pituitary gland. This was a major step forward in the search for a better understanding of the etiological factors in diabetes mellitus. It demonstrated that an excess of one hormone may produce an insufficiency of another. It also showed that such an excess, operating for a limited period, may lead to permanent impairment of pancreatic hormonal function and an experimentally induced diabetic condition. From clinical experience, White and Pincus concluded that there was evidence of a tempor-

ary hyper-pituitarism during the period of abnormal growth in children which frequently precedes the onset of diabetes.

ADRENAL GLAND

In considering the effects of the adrenal gland on carbohydrate metabolism, there is little evidence at the present time to support the contention that human diabetes may be induced by the action of adrenalin. The immediate hyperglycemic and glycosuric action of adrenalin, produced by emotional tension, has been well established. Houssay felt that neither cortin nor any adrenal substance had a diabeticogenic action. Long differed with him and was impressed with the occurrence of defects in carbohydrate metabolism in adrenalectomized animals. He argued that the similarity of the effect on diabetes in hypophysectomy and adrenalectomy was due to the fact that one or all of the hypophyseal hormones exerted their influence upon metabolism through stimulation of the adrenal cortex. Tumors of the adrenal cortex have been found in association with diabetes mellitus. (Aschard-Thiers syndrome). Experiments upon the effects of ACTH in hypoglycemia have supported Long's contentions.

THYROID GLAND

In humans, total thyroidectomy ameliorates the symptoms of diabetes. Hyperthyroidism is an unfavorable complication when occurring in conjunction with diabetes. In a series of cases studied at the Ford Hospital, Foster and Lowrie found that the incidence of diabetes was 2.43 per cent of those with a primary diagnosis of hyperthyroidism. Menninger referred to a case of psychogenic thyroid disturbance with diabetes, reported by Newburg and Camp, in which the diabetes cleared up following psychotherapy.

GONADS

The role played by the sex hormones in carbohydrate metabolism is not clear. Disturbance of the sexual functions in diabetes mellitus is frequently mentioned as a complication. The question arises as to whether these are primary or secondary manifestations of the disease. Menninger feels that impotence and frigidity are not caused by the disease except in extremely severe cases. Daniels gives an example of a case of clinical diabetes which illustrated a close relationship between the suppression of sexual drive and an increase in diabetic symptoms. With the return of potency through psychotherapy, the patient's blood sugar dropped and the disease was easily controlled.

PANCREAS

Although there is no question of the importance of the pancreas in carbohydrate metabolism, there is still some doubt as to whether insulin deficiency is the real cause of diabetes mellitus. Only a small percentage of diabetic pancreases show lesions at autopsy. Assays of the pancreas in diabetics do not necessarily show an insulin deficiency. Thus it should be recognized that there remains much to be learned about the inter-action of the hormones produced by the endocrine system.

AUTONOMIC NERVOUS SYSTEM

The influence of the nervous system upon diabetes mellitus cannot be overlooked. There is a question as to what degree it enters into carbohydrate metabolism regulation and disturbances. The hypothalamus is that portion of the central nervous system which may give the key to some disturbances of carbohydrate metabolism, especially those secondary to emotional upsets. Whether these disturbances are due to the loss of a direct and specific control or to an indirect influence of the hypophysis, the pancreas, the adrenal cortex or the gonads is not known. Masserman feels that too much function has been relegated to the hypothalamus. He does not feel that it is the center of emotional life, (Freud's Id), but a center where afferent impulses are integrated for the expression of emotions. He postulates that the feeling aspects are probably taken care of by the thalamus and the thalamo-cortical connections. Grinker pointed out that the hypothalamus, as a center for autonomic control, is important for the equalization of impulses arising within the individual. When these are interferred with, anxiety may result and be discharged through the hypothalamus. Anxiety is the first sign of an autonomic influence on the cortex. It stimulates the individual into activity. He must flee, fight or compromise. When one of these solutions cannot be carried out, the cortex tends to "give up" for the sake of avoiding more prolonged states of emotional tension. These impulses are then suppressed and tend to find expression through visceral or organ dysfunctions. This may be the first step in the development of an organic disease secondary to emotional tension.

There is a close relationship between the

hypothalamus and the pituitary gland. The first holds a master position over the autonomic nervous system and the latter serves the same function over the endocrine system. They have a common embryonic derivation and innervation. If there is a direct relationship, and if diabetes mellitus is caused by a temporary or chronic hyperfunction of the anterior pituitary, the hypothalamus would appear to be the route through which emotional disturbances could make their impact.

EMOTIONAL FACTORS

Most authors have brushed aside the importance of the emotional factors in the etiology and course of diabetes mellitus by referring to the hereditary pre-disposition. This has been reinforced by the experience with soldiers during World War I referred to previously. Joslin, who formerly stressed the importance of nervous stress and strain on the course of the disease, reversed his position and stated that whatever influence had previously been attributed to this could now be explained by heredity and obesity. There is insufficient proof that severe psychic trauma is not important in the disease, and several cases of diabetes following severe emotional shock have been reported.

It is an accepted fact that latent diabetes may become manifest in the presence of an acute infectious process. At the present time there is no knowledge of the mechanism involved in the transformation of latent diabetes into actual symptomatic diabetes. Our lack of information does not preclude the possibility of latent diabetes becoming manifest following emotional trauma or prolonged emotional stress.

NEUROTIC MANIFESTATIONS

Neurotic manifestations occur frequently in association with diabetes mellitus. Menninger calls attention to the fact that there is little dissension regarding the importance of the psychogenic factors once diabetes is established. Many have difficulty in accepting the possibility that these same factors may initiate a metabolic disorder. At present there is less emphasis on trying to relate phychogenesis in diabetes to the frequency of occurence following emotional trauma. The trend is not to attribute it to the anxiety, concealed or overt, which is unable to be discharged through the conscious voluntary system and is thus forced to seek outlet in the autonomic nervous system, with secondary effects upon the endocrine system.

MEDICAL PROGRESS

In 1948, Joslin published a rather comprehensive review of the medical progress in diabetes. This review took up a major portion of three issues of the *New England Journal of Medicine*. Only one paragraph was devoted to the psychological and emotional factors in diabetes. In contrast to this, Fischer and his co-workers in the Department of Pediatrics at the Mount Sinai Hospital published three articles stressing psychic factors. The first, "Factors Responsible for Emotional Disturbances in Diabetic Children," appeared in *The Nervous Child*. The second, "Behavior and Other Psychologic Problems of the Young Diabetic Patient," appeared in the *Archives of Internal Medicine*. The third, "The Psychic Aspects of Juvenile and Adolescent Diabetes," appeared in the *Journal of the Mount Sinai Hospital*.

In a study of the personalities of children with diabetes, Loughlin and Mosenthal, of the New York Diabetic Association, observed 114 children attending a camp for diabetic children. They found that 40 per cent of these children suffered from neurotic manifestations or behavior problems. They also noted that ketosis occurred twice as frequently in the poorly adjusted diabetic child. These children seemed to exhibit an over-concern in regard to their illness, were not well accepted by the group, and were less active and agressive than the ones considered normally adjusted. They seemed to lack a sense of security. They seemed to cluded that the early recognition of conflicts and behavior disorders in these children with diabetes would contribute materially towards evolving better adjusted diabetic adults.

Fischer studied 43 diabetics over a ten-year period and outlined the factors that he felt were responsible for emotional disturbances in these children. He felt that these factors were more marked and more difficult to overcome in those from the lower socio-economic group. Diabetes proved less of a problem when the child came from a well adjusted home environment. The factors were: (1) dietary restriction at a time when the child had a need to be like other children, and craved a great deal of carbohydrates as a ready source of energy; (2) the need to give repeated insulin injections, his fear of the injections and their interference with his

play; (3) the stigma of being a diabetic and the fear that others would not accept him because he was a defective child; (4) the tendency of the parents to over-protect the child and curtail his activities; and (5) the future outlook of having to carry on with a chronic condition with little hope of a cure. Fischer concluded that diabetes mellitus was a true psychosomatic condition and that interviews with a psychiatrist, a complete social history of the family and occasional conferences with the parents should be part of the treatment in all cases of childhood diabetes.

In his paper on the behavior and psychologic problems of the young diabetic, Fischer concluded that many diabetic children were rejected because they were an increased burden to their parents. These children tended to become quite belligerent. Others, whose parents reacted by over-protecting the child, developed into passive - dependent children who had difficulty in meeting the demands of society as they grew to maturity. Many used their illness to curry special favors. A great many became adroit at feigning insulin reactions. Some were unjustly punished for erratic behavior and irritability when in a hypoglycemic state.

Pollock outlined methods of avoiding emotional disturbances in juvenile and adolescent children with diabetes. He felt that the children needed reassurance that they were adequate individuals. He thought that the parents developed unconscious guilt feelings for the child's condition. The child sensed this and interpreted it as a lack of love and acceptance. He saw no reason why the child could not partake in the normal activities and play with children in his own age group. He warned against the parents using the disease as a threat to the child, telling him that he would have to have bigger shots or that he might die if he did not follow instructions rigidly. He recognized the parents need for help in overcoming their anxiety about the child's condition. He favored allowing some dietary indiscretions and covering them with insulin without reprimanding the child. He warned against calling this cheating. He also advised psychotherapy along with control of the diet and the administration of insulin in the treatment of the diabetic child.

TREATMENT OF THE DIABETIC CHILD

Many physicians tend to be too didactic in their handling of diabetic cases. They forget that good medicine means the handling of each case as an individual problem. It may sound simple to tell a patient that he can live a normal life in spite of his disability, yet the patient will need constant reassurance. He has a need to talk over his problems with the physician, not only those concerned with diet and administration of insulin, but anything that might be a source of anxiety. Early help of this kind will help him adjust more readily.

Loughlin stated "the child is indeed fortunate who is treated at a clinic or by a physician who can control the diabetic condition without instilling the ever-present consciousness of calories, carbohydrates, urinalysis and insulin injections." She felt that diabetic children, whose parents would not accept the reality of the condition and continually sought remedies that promised cure, were good candidates for the development of a neurosis. Many of these children complained of headache, backache, fatigue, palpitation and other somatic symptoms.

CASE HISTORIES

A brief review of four case histories is presented to illustrate some of the effects of emotional factors upon the course of the disease.

Case 1. Adolescent female, diagnosis first made at age 11. This girl was placed on a rigid schedule of diet and insulin. She was an active, aggressive youngster of superior intelligence and soon rebelled against these restrictions. Before long she had taken over complete management of her diabetes. She estimated the carbohydrate content of her diet without weighing or measuring the food. When she wanted to partake of extra sweets on special occasions she merely increased her insulin. She varied this from 60 to 100 units of regular insulin daily, depending upon a morning urinalysis and also upon her mood. She was active in school and civic affairs and was popular with her classmates. With the exception of occasional attacks of hypoglycemia there was little evidence that her illness interferred with the normal activities of an adolescent girl. She completed high school and graduated as valedictorian of her class.

At the age of 18 she developed an acute abdomen necessitating surgery for the removal of her appendix. The day following operation she was directing the dietitian in the preparation of her meals. Enough carbohydrates were included to produce an ele-

vated blood sugar in even a mild diabetic. In spite of this her blood sugar was only slightly elevated and her urine showed only traces of sugar during the following five postoperative days. Within a week after her discharge from the hospital her diabetes had resumed its usual course, requiring 60 to 80 units of insulin daily for control.

Emotional factors could have been responsible for this temporary decline in the severity of her diabetes. During hospitalization, this aggressive and dynamic individual was able to assume a rather passive-dependent role. This may have resulted in a diminution of impulses discharged through the autonomic nervous system reacting upon the hypophysis, producing an excess of anterior pituitary substance. Experiments, previously mentioned, have shown that such an excess interferes with the production of insulin in the pancreas.

At the age of 19 this patient began a rather stormy courtship. Several times during this period she developed severe hypoglycemic comas in the early morning. It was determined that these spells occurred several hours after having sexual intercourse. This emotional experience may have drained off excessive impulses previously discharged through the hypothalamus, resulting in a change in hormonal balance.

For three years following marriage her diabetes remained in relatively good control. She then began having difficulty with her mother-in-law and was complaining of poor marital adjustment with resultant frigidity. During the next two years she was hospitalized several times for treatment of her diabetes. Her husband finally severed a business partnership with his mother and started a similar venture on his own in another community. Since that time the patient's diabetes has stabilized along with her emotional state. It would appear that the emotional state of this patient had a direct influence upon the course and severity of her diabetic condition.

Case 2.: Middle-aged farm wife, a known diabetic for over ten years. This patient was married to a chronic alcoholic and was the mother of six children. There was a continual state of unrest in this family and the patient's diabetes was constantly fluctuating in spite of close medical supervision. The husband was finally prevailed upon to take treatment for his alcoholism. This proved successful and was followed by an improved emotional environment for the patient. She soon had her diabetes under excellent control and was able to reduce her daily insulin requirements between 25 and 30 units daily. During the next four years that she was followed she was seen only at infrequent intervals for routine office check-ups.

Here we see a case of diabetes under poor control when undergoing prolonged periods of tension that improved in control and insulin requirements when the cause of emotional upsets were reduced.

Case 3.: Juvenile male, diagnosed as diabetic at age seven. This lad came from a home where the economic status was marginal. His mother was over-protective and his father was an inadequate individual who neglected the family. The parents had poor control of the boy and would often omit his insulin injections rather than be faced with his tantrums. He was expelled from school for stealing candy, cake and cookies from the other children's lunch boxes. He was apprehended for taking candy from the local stores. On several occasions he developed a severe state of acidosis. Following these episodes his mother would "bear down" on him for awhile but eventually lasped into her haphazard methods of management. She constantly blamed the doctors for his poor state of control.

At the age of 15, this patient was admitted to a large medical center for treatment. He weighed 52 pounds. His body was covered with pyogenic lesions. He remained in the hospital for three and a half months. During this time he was a behavior problem on the ward. He would feign insulin reactions and had frequent temper tantrums. Unless under constant supervision he stole food. He wrote his parents that he was being cruelly treated and they finally removed him from the hospital against medical advice. Within three days he was re-hospitalized for treatment of a diabetic coma.

This case illustrates the difficulty in controlling diabetes in a child when the parents are uncooperative and the home situation unstable.

Case 4.: Adolescent juvenile delinquent female. This girl was a severe diabetic for three years. Her family had little or no control of her. She was hospitalized on several occasions for treatment of her diabetes and an intercurrent luetic infection. At one time she suffered a mild cerebral accident with right hemiparesis. She was finally adjudged

incorrigible and sent to a correctional institution. While there it was impossible to control her diabetes unless she was kept in a hospital. She was finally paroled to her mother and psychiatric treatment was recommended by the Court. During the following year and a half, while under psychotherapy, her diabetes remained in moderately good control. This was the longest period, following onset of the disease, that she had remained free of complications. Her mother reported that she was adjusting better than at any time since she was eleven.

This case illustrates moderate improvement in the control of a diabetic condition in a patient receiving psychiatric treatment.

SUMMARY

Diabetes mellitus is an endocrinopathy whose onset and course may be altered by the emotional state of the individual. The emotional factors require evaluation in the treatment of the disease. The proper psychological emphasis may spell the difference between the successful or unsuccessful management of the disease. One must treat the individual and not just his diabetes.

Diabetic maturity is rarely achieved at present. Medical science gave the diabetic patient a new lease on life with the discovery of insulin. It has much to learn about the management of the diabetic.

No diabetic can be adequately treated unless there is some consideration of the emotional problems that he faces. Consideration of this aspect is as important as his diet, urinalysis and insulin injections.

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Meet Our Contributors

Arnold H. Ungerman, M.D., and *Milford S. Ungerman, M.D.*, Tulsa, have a paper in this issue on "Toxic Encephalopathy Occurring During Topical Treatment for Tinea Capitis." Dr. Arnold Ungerman was graduated from the University of Oklahoma School of Medicine in 1934 and he also holds a B. S. degree in addition to his M.D. His specialty is neuropsychiatry and he is a member of the American Psychiatric Association, Mid-Continent Psychiatry Association, Medical Society of St. Elizabeth's Hospital, Southern Medical, etc. Before coming to Tulsa, he had practiced in Washington, D.C., as a medical officer with the United States government for nervous and mental diseases, and neuropsychiatric medical officer for the U. S. Indian Service. Doctor Milford Ungerman was graduated from the University of Oklahoma School of Medicine in 1945 and his specialty is also neuropsychiatry. He is a member of the World Federation for Mental Health, American Psychiatric Association, Central Neuropsychiatric Association and Oklahoma Society of Neurologists and Psychiatrists.

James C. Sargent, M.D., Milwaukee, wrote the article on "Bladder Tumors, Their Diagnosis and Treatment," in this issue of the Journal. Doctor Sargent was graduated from the Ohio State University College of Medicine in 1915. Doctor Sargent limits his practice to his specialty, urology, and has been certified by the American Board of Urology. He is a member of the North Central Section, American Urological Association, American Urological Association, American Association of Genito-Urinary Surgeons and Americans College of Surgeons. He is chairman of the Council on National Emergency Medical Service of the American Medical Association.

Paul C. Benton, M.D., B.A., Tulsa, is the author of "The Emotional Aspects of Diabetes Mellitus," and was graduated from the University of Minnesota in 1936. Doctor Benton limits his practice to child psychiatry. Doctor Benton is a member of the American Psychiatric Association and the Mid-Continent Psychiatric Association. He was previously instructor in the Department of Psychiatry and Pediatrics at the University of Minnesota Medical School in Minneapolis.

Three Oklahoma City physicians, *Donald D. Albers, M.D., J. Neill Lysaught, M.D.*, and *Edmond H. Kalmon, M.D.*, collaborated in writing the article, "Diagnosis and Management of Urinary Tract Infections in Children" which appears in this issue of the Journal.

Doctor Albers was graduated from Northwestern University in 1943 and also holds a B.S. degree and M.S. in physiology and in urology. He limits his practice to his specialty, urology and is a member of the South Central Section of the American Urological Association.

Doctor Kalmon, who was previously located in Albany, Georgia, was graduated from Vanderbilt Medical School in 1940. He limits his practice to his specialty, radiology, and has been certified by the American Board of Radiology. Doctor Kalmon also holds a B.S. degree. He is a member of the American College of Radiology and the Osler Society.

Doctor Lysaught, formerly instructor in pediatrics at Johns Hopkins University School of Medicine, was graduated from Kansas University in 1944. Certified by the American Board of Pediatrics, he limits his practice to his specialty. Doctor Lysaught also holds a B.S. degree. He is a member of the American Academy of Pediatrics.

RIGID WIRE FIXATION OF FRACTURES IN THE HAND*

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Unrestricted, painless function of the hand is of utmost economic and cosmetic importance to the patient. Thus, fractures of the phalanges and the metacarpals present a challenge to both physicians and patient. Many of these fractures can be treated by manipulation and splinting of the affected bones in the position of function. Other fractures, because of a tendency to displacement, require more firm fixation or traction. Rigid wire fixation merits consideration in the treatment of these injuries of the hand. It is our purpose to present this method of fixation, which is not at all new but has proved itself superior to traction, plates or other methods of treatment.

Short rigid wire fixation of fractures is more commonly used than is indicated by the literature, and proper credit for priority use is not always possible. Recently Vom Saal[1] clearly described intramedullary or longitudinal fixation of fractures of the phalanges and metacarpals. He did not mention oblique or transverse fixation which is of

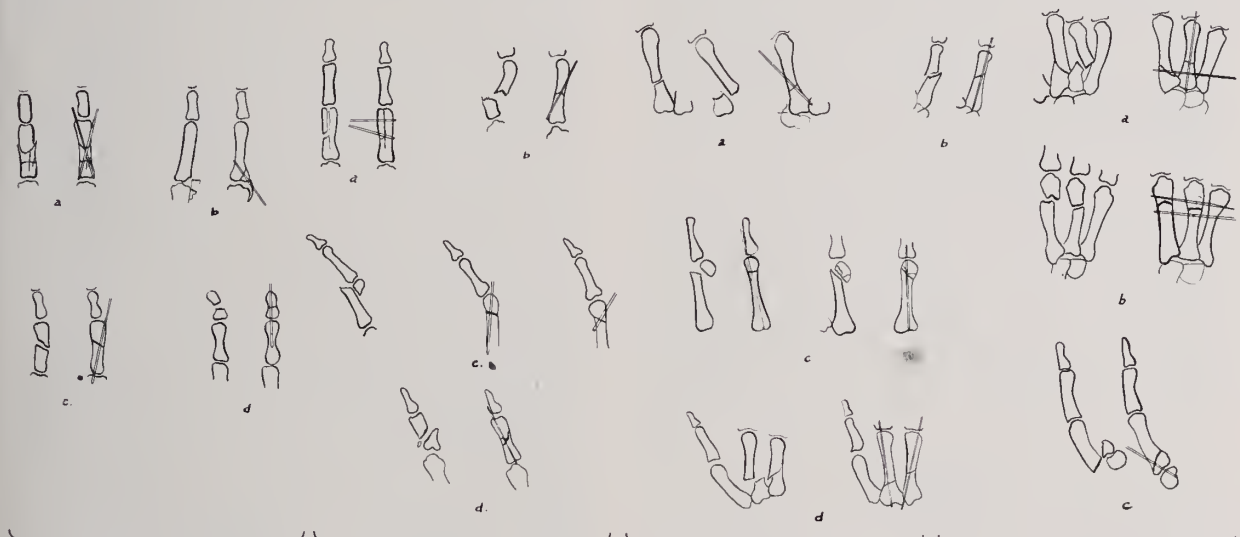


FIGURE 1. FIGURE 2. FIGURE 3. FIGURE 4.

FIGURE 1.

a. *In comminuted fractures of the phalanges, length may be maintained as well as immobilization of the several fragments by crossed wires.*
b. *The marginal chip fracture of the base of a phalanx may seem small and insignificant if it does not involve much of the joint surface. But the loss of stability due to lack of the collateral ligament is very important, and can be avoided by pinning the fragment back accurately.*
c. *Slightly oblique longitudinally placed wire causes minimum interference with extensor mechanism in this simple fracture of a phalanx.*
d. *Fractures of the distal phalanx often result in non-union if not securely held by rigid wire fixation.*

FIGURE 2.

a. *A chip fracture involving a joint surface may slip or rotate if not held by two small transverse wires. Maintenance of a smooth joint surface is essential to good motion.*
b. *This displacement is produced by the intrinsic muscles of the hand. Placing the fingers flexed around a roll may not maintain reduction. The wire is oblique in the anteroposterior plane also.*
c. *The fracture of the neck of a phalanx may be held by a longitudinal or an oblique wire.*
d. *Several small fragments may be "threaded on" an intramedullary wire.*

FIGURE 3.

a. *Fractures of the bases of metacarpals tend to be displaced by wrapping the hand around a roll. With or without displacement they should be fixed with a short rigid wire.*
b. *Oblique fractures of metacarpals have a strong tendency to proximal displacement and just enough angulation to impair finger function. Longitudinal or oblique pinning may be used.*
c. *Fractures of the neck of metacarpals are common. With proper immobilization, a depressed knuckle can be avoided and excellent function obtained, even if the fracture is oblique or comminuted.*
d. *Multiple fractures are much more easily handled by rigid wire fixation.*

FIGURE 4.

a. *The combination of longitudinally placed and transversely placed wires often adds stability to short fragments by pinning them to intact adjacent metacarpals.*
b. *In the use of transverse wires, it is often better to fix both the proximal and distal fragments to the solid metacarpal. These wires may be more obliquely placed if desired.*
c. *Bennett's fracture or other fractures in the region of the base of the 1st metacarpal are much more accurately and securely fixed by the use of a rigid wire.*

*Presented before the General Session at the Annual Meeting of the Oklahoma State Medical Association April 14, 1953.

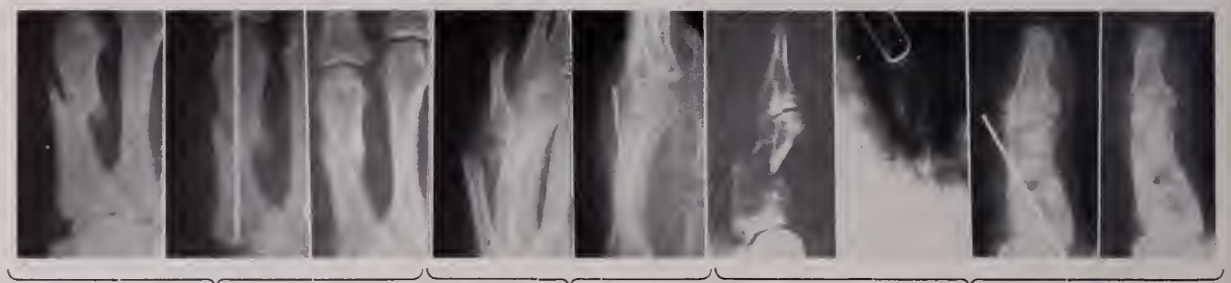


FIGURE 5. FIGURE 6. FIGURE 7.

FIGURE 5.
Simple fracture of shaft of metacarpal with slight comminution, proximal and medial displacement and rotation of distal fragment, reduced and held well by single K wire which engages cancellous bone at each end of metacarpal.

FIGURE 6.
Pugilist fracture of neck of fifth metacarpal. A depressed knuckle may result if distal fragment is not held until healed. A single wire longitudinally placed does this very well.

FIGURE 7
This comminuted fracture of the proximal phalanx of the thumb did not heal with wire traction because of distraction and motion at the fracture site. Oblique wire for internal fixation was then placed nearly perpendicular to the main fracture line. Healing was slow but solid.

equal importance. It was pointed out some time ago, by Waugh and Ferrazzano[2], that all the joints, interphalangeal and metacarpo-phalangeal, should be held at right angles when the wires are inserted. Berkman and Miles[3], in treating fractures of the metacarpals, used transverse pins holding the fractured bone by means of pinning it to the solid adjacent metacarpal.

There is no short-cut in the technique of rigid wire fixation of fractures of the hand. It requires strict asepsis, operating room facilities, adequate anesthesia and x-ray facilities. The Kirschner wire is commonly used. However, in some instances, threaded wires are desirable. The new triangular and diamond shaped rigid wires may be used to prevent rotation in selected cases. The wires are most easily handled by the small drills particularly adapted for hand use but the Kirschner wire drill may be used if the other drills are not available. The selection of local or general anesthetic depends on the location, multiplicity of fractures, type of fracture and the patient's temperament. If local anesthesia is used, the surgeon should be very familiar with the anesthetic agent and hand surgery. The use of epinepherine is contraindicated with local anesthetics about the hand. The new preparations with hyaluronidase as a spreading factor, have proved most acceptable and providing good anesthesia with no vascular side effects.

The hand is scrubbed, prepped and draped, as in all surgical procedures. The fracture is reduced by closed manipulation if possible. The wire is inserted directly through the skin toward the bone to be penetrated. It must initially be started at right angles to the cortex to get a small "bite" on the bone, after which it may be directed as desired. In using a longitudinal or diagonal wire, it is started through the phalanx or metacarpal, beginning slightly to the side of the distal joint surface as near the center of the bone in the anterior-posterior diameter as possible to avoid injury to nerves and blood vessels. The wire is carried proximally until it penetrates the proximal end of the bone. If the joint surface is traversed by a wire, no permanent damage results. Frequent x-ray films are made to insure ac-



FIGURE 8. FIGURE 9.

FIGURE 8
Skin traction was unsuitable to reduce ormaintain reduction of this fracture of the neck of a phalanx. Obliquely placed wire penetrates joint margin and opposite cortex.

FIGURE 9
This oblique fracture of the base of a metacarpal with dorsal displacement is most difficult to maintain by any other means but is most efficiently held by a single oblique wire.

curate positioning of the wires. If the wire has been placed in error, a second wire is inserted before withdrawing the first. This eliminates the possibility of the second wire following the path of the incorrect one.

If the fracture is seen early and the swelling is minimal, palpation will reveal whether or not one wire brings about sufficient rigidity to hold the fracture. On occasion, it is necessary to expose the fracture to secure accurate apposition of the fragments. If one wire does not provide sufficient rigidity, it may be necessary to transfix the bones with crossed wires which, in addition to giving more rigid fixation, will prevent rotation better than the single longitudinal wire. When properly placed, the wires should be cut just beneath the skin level.

It is usually necessary to apply some form of splint; the extent of the splint will vary with the location and type of fracture. Phalangeal fractures may be fixed with a flexed aluminum splint while metacarpal fractures ordinarily require plaster splinting of the hand and forearm. As much of the hand as possible is kept free and mobile so that stiffness will be minimal.

Careful follow-up observation is required and this again varies with the type and extent of injury to the hand. Patients with uncomplicated phalangeal fractures may be dismissed a few hours following the surgery, provided the hand shows no evidence of circulatory disturbance. All patients must be warned concerning post-operative edema and circulatory embarrassment and should return for post-operative check the following day and then may be followed at five to seven day intervals.

If the post-operative course has been uncomplicated and the fracture is in evident good alignment and fixation, follow-up x-rays are repeated in the second or third week. The rigid wire may be removed when there is reasonable assurance that bony union has taken place. The x-ray is of help but it should be remembered that callus formation in the phalanges is poorly demonstrated roentgenologically.

To remove the wire, infiltrate local anesthesia into the skin directly over the tip of the wire, make a small stab wound slightly larger than the diameter of the wire, push the skin back over the wire until it protrudes and grasp it firmly with a sterile needle holder or pliers; rotate until it is loose and then rapidly withdraw.

Compound fractures present the problem of fracture fixation complicated by contamination, potential or evident infection, vascular, nerve and tendon damage, and skin loss. Each case must be individually evaluated. If the hand is seen shortly after injury, contamination appears minimal, skin coverage good, the fracture should be repaired, after thorough washing and debridement, and the wound closed immediately. If there is severe skin, tendon and vascular damage with evident infection, treat the soft tissue injury and fix the fracture later. Rarely, one will be presented with a hand injury where the traumatic insult is of such severity that it is necessary to preserve the architecture of the hand as well as provide skin coverage immediately. These can be best handled by fixation of the fractures with wire and simultaneous skin grafting. Pressure dressings and splints are applied. The immediate post-operative care of the compound fractures requires antibiotic therapy, tetanus toxoid or antitoxin and analgesics. Trained personnel must keep frequent watch of the circulation in the digits until danger of swelling or gangrene is passed. As soon as the skin is healed, follow-up care is similar to that of a closed fracture.

Conclusions

It is felt that the methods described here are of unlimited value in the fixation of fractures about the hand. The method is safe, reasonably simple and results in an adequately functioning hand with minimal disability.

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TOXIC ENCEPHALOPATHY OCCURRING DURING TOPICAL TREATMENT FOR TINEA CAPITIS*

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Wilson et al.,[1] Hitch,[2] and Featherston[3] reported several patients with tinea capitis who developed neurotoxic symptoms following the use of the antifungal agent, Asterol[R] Dihydrochloride. We have recently had occasion to observe two instances of encephalopathy which occurred during treatment with this drug and with salicylic acid ointment, and wish to report these cases today.

Two siblings, a girl, age three and a half years, and a boy, age four and a half years, had shown circumscribed and disseminated areas of hair stubbles and thinning of the hair at the sites of the lesions for several weeks prior to seeking medical advice. When these children were first seen by Doctor Showman, the infected areas showed bright green fluorescence under the cobalt-filtered ultraviolet light. A diagnosis of tinea capitis was made and M. audouini was subsequently determined as the offender by cultural procedures. Five per cent Asterol Dihydrochloride Tincture was prescribed. One-half dram of this drug was applied twice daily and massaged into the scalp. This was followed with an ointment containing five per cent salicylic acid and ten per cent sulfur in an Aquaphor base. Cotton stocking caps were worn for most of the time.

Nine days after initiation of this program, changes in the behavior pattern of both children were noted. Nightmares and visual and auditory hallucinations (butterflies, worms, insects, and bears) occurred. Marked anxiety and irritability were evident. The mother observed listlessness, disorientation, lethargy, and somnolence. All these symptoms were more marked in the younger child, in whom intermittent gross muscular twitchings also appeared, but no convulsions.

When first examined by us two weeks after initiation of treatment, both children appeared listless and lethargic. There was complete loss of interest in the surroundings with lack of spontaneity and initiative. Temperature, pulse rate, respiration, and blood pressure readings were normal. No sensory changes were apparent. Neither of the children had convulsive seizures during the examination. The equilibrium was disturbed, the gait ataxic, and generalized muscle tremors, both tonic and clonic, were noted, particularly in the upper extremities. The deep reflexes were hyperactive. Marked psychomotor retardation prevailed. In addition, examination of the younger child revealed dilatation of the left pupil which did not react to either light or accomodation; otherwise, there was no abnormality of the cranial nerves. The optic fundi of both children were normal, as were the hemograms, the blood serology and the urinalyses. The results of cerebrospinal fluid examinations were within normal limits in both patients and the spinal fluid Wasserman tests were negative.

Electroencephalographic studies were carried out for both children. The tracings made during toxic reaction of the younger child are reproduced in the upper section of Figure 1. As can be seen, there was an extremely severe generalized and continuous form of cerebral dysrhythmia with an increase in the amplitude of 100 to 150 microvolts and a decrease in the frequency to as low as one cycle per second. There was no apparent localization. Hyperventilation did not appear to be appreciably different from other parts of the recording.

The tracings made during toxic reaction of the older child are shown in the upper section of Figure 2. There existed an extreme degree of cerebral dysrythmia with a marked increase in the amplitude and a decreased frequency. The amplitude reached as high as 150 microvolts and the frequency dropped as low as one to one and one-half cycles per second. Such rhythm was generalized throughout the entire record and noted in all leads. There was no particular change during hyperventilation from the pattern noted previously.

In both instances, a diagnosis of generalized encephalopathy was made.

*Presented before the Section on Neurology and Psychiatry at the Annual Meeting of the Oklahoma State Medical Association April 13, 1953.

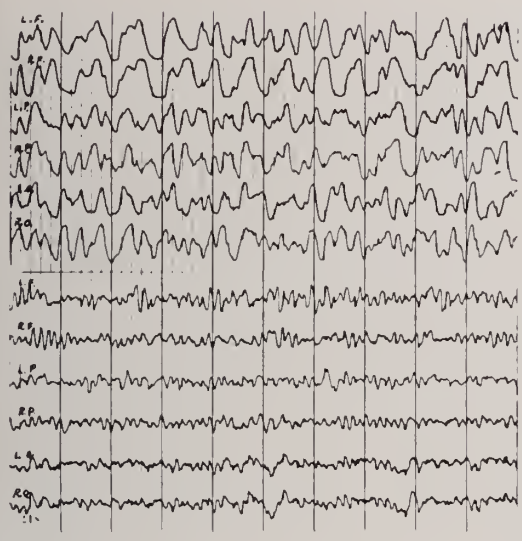


Figure 1. Electroencephalograms of 3-1/2 year old patient.
Upper portion: Tracings during toxic reaction.
Lower portion: Tracings two months later.

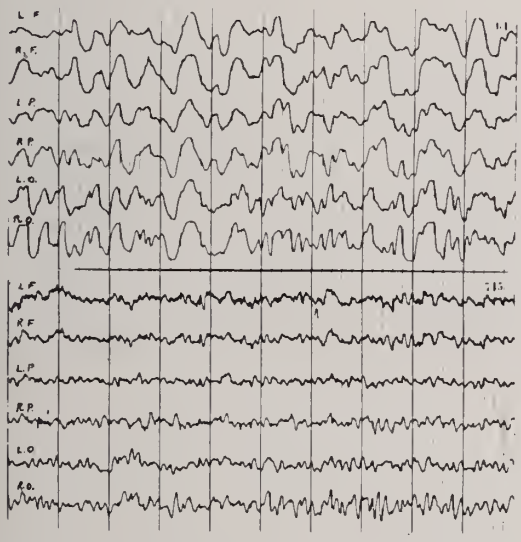


Figure 2. Electroencephalograms of 4-1/2 year old patient.
Upper portion: Tracings during toxic reaction.
Lower portion: Tracings two months later.

All scalp treatments were discontinued and both children carefully observed, but no specific therapy was given. Temperature, pulse rate, respiration, blood pressure readings remained normal during the period of observation. The hallucinations persisted for four days and the muscular twitchings and the ataxia for seven days. The behavior pattern gradually became normal. All neurological signs returned to normal in both children within 21 days. The electroencephalograms repeated two months after the first tracings are reproduced in the lower portions of Figure 1 and 2. As can be seen, the tracings made after recovery of the younger child represented an essentially normal electroencephalogram. The post-recovery tracings of the older child still showed occasional scattered slower dysrhythmic waves appearing in paroxysmal bursts as well as some small areas of continuous activity. Hyperventilation did not produce an appreciable build-up. This is a borderline normal electroencephalogram showing marked improvement over the tracings made two months previously.

DISCUSSION

A total of six cases are reported in the three articles[1, 2, 3] which have recently described neurotoxic phenomena as possible side reactions from Asterol. Two of these patients were infants and in one case, observed by Doctor Fishman, Asterol was ruled out as the offender because the "patient's condition was apparently psychogenic" and "antedated the use of Asterol[R] Dihydrochloride." In another case—that observed by Doctor Stritzler — "the medicament was applied in enormous amounts and was held in close apposition to the skin by an impervious dressing."

It is evident that the circumstances prevailing in these four instances and in our two cases are quite different. However, the two remaining patients of the six recently reported, viz., one of the two described by Wilson et al. and that observed by Hitch, and our two patients have several features in common, but are somewhat dissimilar in other respects. The Wilson case was a four-year-old and the Hitch case a three-year-old boy. Thus, both these children are in the same age bracket as the patients we presented. Unlike the cases reported by Wilson and by Hitch, in which Asterol was the only medicament employed, our patients were treated with this drug and with a salicylic acid ointment.

The Wilson case exhibited muscle tremors, hallucinations, and disorientation, but no convulsions. Obviously, the symptomatology of this child and of our cases is very similar. Also, the onset of disturbances in the Wilson case and in our patients occurred at the same time in relation to the initiation of treatment, namely, nine days after its institution, and the amounts of Asterol used were not excessive in any of these three instances. Finally, in the Wilson case, as in our cases, the hallucinations and the other neurological symptoms disappeared a few days after discontinuance of topical therapy. On the other

hand, the deviations in the electroencephalographic tracings of the patients we observed are much more clearly defined than those recorded for the Wilson case.

The patient observed by Hitch had hallucinations, but unlike our cases, also had convulsive seizures. Furthermore, in contrast to our cases, the patient reported by Hitch developed an inflammatory reaction which may have led to excessive cutaneous absorption. Unlike our cases, neurotoxic symptoms did not appear in the Hitch case until 53 days after treatment had begun. On the other hand, they disappeared completely in a few days after discontinuance of Asterol, as was the case in the two children we reported.

It is not a simple problem to prove whether or not in our cases there actually existed a causal relationship between the local application of Asterol and the observed neurotoxic symptoms. Above all, Asterol was not the only medicament applied. As previously stated, both children were treated also with an ointment containing five per cent salicylic acid and ten per cent sulfur, salicylates given orally in large doses have been previously incriminated to be capable of causing toxicity phenomena among other symptoms by restlessness, delirium and hallucinations. Recently, Cawley, et al.[5] have reported two children who developed salicylate poisoning during treatment with salicylic acid ointments. The symptoms of one of these patients included crying spells, loss of appetite, "delusions of insects crawling on her bed," an da semistuporous state. It is worthy to note that an electroencephalogram done for this child the day on which the diagnosis of salicylate poisoning was made, revealed an abnormal pattern. The other patient, too, showed mental disturbances attributed to the topical application of salicylic acid ointment, no doubt about then. Our two cases were exposed to two agents, namely, Asterol and salicylic acid, both of which have to be considered as possible offenders. However, the quantities of salicylic acid ointment applied to our patients was no doubt much smaller than the amounts used in the two cases reported by Cawley and his collaborators. Also in our cases there was a complete absence of the usual gastro-intestinal symptomatology which accompanies salicylic acid poisoning. Therefore we feel that this salve did not play an important part in precipitating the neurotoxic phenomena in our two cases.

In regard to the significance of electroencephalograms, it is worthy of note that tracings of normal children may show great variations. Moreover, with respect to the electroencephalograms made for our two patients during the toxic reactions, it is obvious that the abnormalities were less pronounced in the younger child, although her clinical symptoms were more marked.

However that may be, cortical disturbances were evident in the electroencephalograms carried out for both of our patients at the time of the most severe central nervous system disturbances. Furthermore, electroencephalographic tracings done two months after discontinuance of topical therapy revealed a return to a normal pattern in three and one-half-year old girl and a marked improvement in the four and one-half-year old boy. Of course, the possibility cannot be ruled out that factors other than Asterol and/or salicylic acid may have produced the changes. For instance, it is conceivable that tinea capitis *per se* may elicit deviations in the electroencephalogram, but we have no control tracings showing the effect of this disease before institution of Asterol and salicylic acid ointment. Similarly, it is conceivable that daily treatment of the scalp with inert materials and the concomitant emotional upheaval may elicit changes in the electroencephalographic tracings. However, changes reflecting any type of emotional upheaval are usually characterized by a fast rhythm and not by a slowing of the rhythm.

If we assume that Asterol has neurotoxic potentialities, it stands to reason that the likelihood of such reactions will be the greater, the younger the patient and the greater the quantities of the drug applied. Warnings against the use of Asterol in infants have been appearing on all commercial packages for about a year. The manufacturers have recently informed us that in the future the caution statements incorporated in the literature and directions for use on all packages will specifically mention that the drug should be discontinued in the event of neurotoxic reactions in children. It is to be hoped that the observations of central nervous system disturbances reported in the literature as well as such warnings on package labels and in promotional literature will prompt physicians to exercise great clinical caution in the use of this product.

It is worthy of note that no convulsive seizures occurred either in our cases or in the boy reported by Wilson et al. In these

three children Asterol was discontinued nine to 14 days after its institution, when tremors, hallucinations, etc., were observed. In contrast convulsions did occur in the case reported by Hitch; they appeared 53 days after treatment was begun. One may speculate that a more observant mother might have detected less alarming symptoms, such as those noticed in the aforementioned three children, at an earlier date and that subsequent discontinuance of the drug might have prevented the occurance of seizures.

SUMMARY AND CONCLUSIONS

Two children, age three and one-half and four and one-half years, are presented who developed neuropsychiatric disorders while undergoing treatment for tinea capitis with moderate amounts of Asterol and of an ointment containing salicylic acid. Hallucinations, muscle tremors, ataxia and other nervous disturbances occurred nine days after initiation of the therapeutic program; convulsions did not occur. Electroencephalographic tracings revealed cortical disturbances in both patients. Four days after discontinuance of topical treatment hallucinations, and three days later the muscular twitchings and the ataxia, disappeared. Three weeks after discontinuance of therapy, all neurological signs returned to normal. Electroencephalographic studies repeated two months after cessation of the topically applied drugs showed apparently normal tracings in the three and one-half-in similar instances of toxic encephalopathy, possibly attributable to Asterol.

The features of these two cases are compared with those described by other authors in similar instances of toxic encephalopathy, possibly attributable to Asterol.

Since it has been claimed that salicylic acid applied topically has caused nervous and mental disturbances and since our patients were treated both with Asterol tincture and salicylic acid ointment, the causal relationship between the administration of the former drug and the neurotoxic phenomena cannot be proven.

Nevertheless, utmost caution is indicated if Asterol is used in young children.

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HILL-BURTON PROJECTS SLATED FOR OKLAHOMA

Fifteen hospital and health center projects in Oklahoma have been placed on the Hill-Burton federal aid hospital construction schedule for 1953-54, Grady Mathews, M.D., State Health Commissioner, announced.

The new building schedule was pared to keep within a reduced federal allocation of $1,319,413 for the year, $224,587 less than last year's. Six projects proposed were postponed.

Under the program, local sources pay half the cost of construction.

Estimated cost of the 15 jobs, when completed, is $7,758,000 of which the federal share is $3,545,523.

Faced with the federal cut, Paul Snelson, head of the health department's hospital division, explained the state health board voted to delay some of the proposed jobs rather than make cuts on individual projects.

Five new general hospitals which will receive allotments this year are already under construction. These projects and their 1953-54 allotments are: El Reno municipal hospital, 40 beds, $52,771; Grand Valley hospital (county) in Pryor, 32 beds, $100,000; McCurtain county hospital, Idabel, 24 beds, $50,000; Southern Oklahoma Memorial hospital (matching funds supplied by a non-profit association), Ardmore, 100 beds, $225,000; Blackwell general hospital (Catholic) 60 beds, $100,000.

AUTHORITIES TO APPEAR ON ONE-DAY CANCER PROGRAM

From Oklahoma Division, American Cancer Society

Concurrent with this year's annual meeting of the volunteers of the Oklahoma Division, American Cancer Society, a symposium for the physicians of Oklahoma has been scheduled. The guest lecturers will be:

Frank E. Adair, M.D., Memorial Hospital, New York City

Alton Ochsner, M.D., Tulane University, New Orleans

John R. McDonald, M.D., Mayo Clinic, Rochester, Minnesota

John H. Randall, M.D., University of Iowa School of Medicine, Iowa City, Iowa.

All physicians are cordially invited to make plans now to attend this all-day symposium sponsored by the Professional Education Committee of the Oklahoma Division, American Cancer Society. The meeting will be held at the Skirvin Hotel in Oklahoma City on December 4, 1953.

More complete information concerning this meeting will be mailed to all physicians. However, your inquiries are welcome at the Oklahoma Division American Cancer Society, 937 Commerce Exchange Building, Oklahoma City.

DIAGNOSIS AND TREATMENT OF URINARY TRACT INFECTIONS IN CHILDREN*

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This study was prompted by the desire to evaluate certain tests made on urine and to classify as to importance certain symptoms and physical findings in the diagnosis and management of urinary tract infections in children. Fifty cases of uncomplicated urinary tract infections and 10 complicated cases with congenital malformations, were selected for study. The age of the patient varied from a few days to eleven years. These cases, taken from the past three years files, are not a continuous series and the number is too small for detailed statistical analysis, but the study was useful as a background for this report on the general management of urinary tract infections in children.

The first part of this report deals with information derived from study of 50 children with urinary tract infections who were not found to have underlying urinary tract disease. The presence of pus in the urine is essential for the diagnosis of urinary tract infection. All of the patients studied had six or more leukocytes per high power field. Most had many to innumerable white blood cells with clumps. A second examination of the urine was necessary in a few before significant pyuria was detected.



FIGURE 1. An excretory urogram in Case No. 2 revealing only function in the upper segment of the left kidney.

A test for albumin in the urine is not an accurate determination for the presence of a urinary tract infection. Albumin was found in the urine of only 25 of the 50 patients, and six of these 25 had only a trace. Albumin may be present, of course, when no infection exists.

The presence of a large number of red blood cells in the urine does not preclude the diagnosis of a pyogenic urinary tract infection. They may represent a diapedesis from an inflamed area in the lower urinary tract or some sort of glomerular involvement. Their presence, however, does have some relationship to albuminuria, for 80 per cent of those patients who had more than a few red blood cells in the centrifugal sediment also had an albuminuria.

An appraisal of the infecting organism is useful and may be essential for the proper management of these infections, although 60 per cent of the patients respond well to one of the sulfonamides. This might be expected since over 50 per cent were found to have E coli or A. aerogenes in the urine. The presence of a proteus or pseudomonas suggests some underlying obstructive disease. These organisms were found in only one of the 50 in whom such disease was not demonstrated, but were present in five of the second group of ten who had obstructive disease. The others had gram positive organisms, coagulase positive staphylococci being more common than other gamma streptococci or streptococcus fecalis. The presence

*On some of the patients in the second group to be presented surgery was performed by J. Hartwell Dunn of Oklahoma City and John L. Emmett of Rochester, Minnesota.

of organisms and the differentiation between gram negative rods and gram positive cocci can be quite accurately made with a gram stain. Only by means of culture can the organism be identified and sensitivity tests done to various antibiotics and chemtherapeutic agents when the initial therapy fails or the infection recurs.

Symptoms referable to the urinary tract, such as frequency, dysuria or incontinence, were present in only one-half of the patients. Some had only an unexplained fever (25 per cent), while others had vague generalized abdominal pain and tenderness (20 per cent), or pain and tenderness in the kidney region (20 per cent). The constitutional reaction to the infection in the children ranged from a low fever to a severe toxemia and high fever with a few having convulsive seizures. It is interesting that all but six of the first group of 50 and all but two of the second group of ten were girls.

The initial management of a newly discovered urinary tract infection is the responsibility of the pediatrician or general practitioner. In our series 60 per cent were treated successfully with one of the sulfa drugs, using one to one and a half grains per pound of body weight per day for five days. A few had penicillin and the rest had one of the broad spectrum antibiotics. Treatment is usually started with the detection of pyuria in a voided specimen. It is our policy, in small infants where catheterization is necessary to obtain an initial specimen, to collect the specimen in a sterile container and if pus is present to culture the urine. Failure in this group occured only when the infecting organism was not sensitive to the agent used. Having the organism for sensitivity tests affords a means of specific treatment without too much delay in small infants who do not respond to initial treatment. The urine is cultured in all patients who do not respond rapidly or whose infection recurs, and sensitivity tests are set up against all the broad spectrum antibiotics, penicillin, erythromycin, streptomycin and polymixin.

In boys urinary tract infections are so uncommon that a thorough workup perhaps after the first infection and certainly after the second is indicated. In girls the situation is somewhat different since urinary infections are much more common. After the third bout of infection we recommend thorough urologic study. A simple but important test is the determination of residual urine by catheterization after voiding. There should be no residual urine or only a few cc. present. Care should be taken to be sure the bladder is emptied. Manual compression is occasionally necessary to make the urine flow through a catheter. Over a few cc. of residual urine on repeated examinations is significant and usually suggests bladder neck obstruction.

An excretory urogram should be done prior to cystoscopy because in many cases the upper urinary tract will be adequately visualized making retrograde study unnecessary. If question still exists concerning one or both kidneys or ureters, retrograde studies should be made. Cystoscopy with careful inspection of the bladder and uretha precedes the retrograde studies and is recommended in many cases even if retrograde studies are not necessary. A retrograde cystourethrogram may help evaluate a bladder neck obstruction or indicate reflux up a ureter.

During the short span of this study ten children have required surgical intervention. This number reflects an incidence probably higher than the average because many of these patients are referred, while many with uncomplicated infections would not be referred. All come from the group whose infection persisted or recurred often. These cases will be briefly reviewed.

Six of the Girls and Two of the Boys Had Vesical Neck Obstructions

Case No. 1. A girl, age 9 was troubled with severe urinary tract infections and



FIGURE 2. A retrograde cystogram in Case No. 2 revealing reflux into a grossly dilated right kidney and its ureter.

bladder symptoms since the age of three. She had a normal upper urinary tract, but had repeatedly 75-90 cc. residual urine. Following bladder neck resection she has had no residual urine and has been free of infections and bladder symptoms in a three year follow-up.

Case No. 2. A five-year-old girl who gave a history of five mild episodes of urinary tract infection in two years. She consistently ran 350-360 cc. of residual urine prior to resection of the vesical neck. An excretory urogram revealed only a small (Fig. 1) upper segment of the left kidney to be functioning and a retrograde cystogram revealed (Fig. 2) reflux up a dilated right and lower left urinary tract. Following resection of the bladder neck her residual urine has remained at 30-60 cc. but she voids more easily and has had only one bout of infection in the one year follow-up. The resection decreased her residual urine and may prolong her life.

Cases No. 3, 4 and 5. These three girls had chronic urinary tract infection with small amounts (15-25 cc) of residual urine. The bladder neck in each looked obstructive. Since the upper urinary tracts were being damaged and the infections were difficult to control resection of the bladder necks were carried out. Conservative measures such as urethral dilation had not seemed to help. The amount of residual urine was reduced to zero in each case. Two of the girls have been markedly improved and one has continued to have an occassional episode of infection.



FIGURE 3. A combined 24 hour delayed excretory urogram and retrograde cystogram in Case No. 7 showing gross dilation of the kidneys and ureters. The marked tortuosity of the left ureter is evident and the bladder shows trabeculation.

Case No. 6. A girl, age 5, had a definite neurogenic bladder resulting from the removal of presacral teratoma shortly after birth. She entered the hospital with the chief complaint of constant dribbling of urine which was thought to be overflow incontinence. She had been resected twice with a six months interval between resections. Her residual urine has been reduced from 120 cc. to 0. The last resections was prompted by a return of significant residual urine and increased dilation of the upper urinary tract.

Only recently, after two years of treatment, has her urine become free of bacteria and pus. She still soils her clothes 2-3 times a day but will be able to go to school without difficulty.

Case No. 7. A boy was discovered at birth to have large bilateral masses which were thought at first to be polycystic kidneys. He was found to have gross dilation of the pelves, calyces and ureters, bilaterally, (Fig. 3.) After catheter drainage for six weeks he was carried on chemotherapy and at eight months had evidence of marked bladder neck obstruction (Fig. 4) The bladder neck was resected through an incision in the perineum. His residual urine came down to zero and the bladder neck appeared open (Fig. 5). He is now 20 months old and has developed normally except that his kidney function remains subnormal. When he gets older surgical correction of the hydroureters may be attempted. His future is not bright.

Case No. 8. A boy with vesical neck obstruction, but less damage to the upper urinary tract, was carried on suprapubic drainage from age of six months to 14 months and tolerated it very poorly. The bladder neck was then resected in two stages through an incision in the

perineum and he had done amazingly well since. Improvement was indicated recently (age 36 months) in his pyelogram as well as in reduction of blood urea. He may be mildly incontinent although it is too early to be certain.

One Girl Had a Uretrocele.

Case No. 9. A girl developed her first infection at the age of two and did not respond to drug therapy. An excretory urogram revealed a filling defect in the left side of the bladder which was proved by cystoscopy to be a large ureterocele. Reaction of the roof of this dilated sac suprapubically resulted in a complete cure.

One Girl Had Complications from Ureterosigmoidostomy for Exstrophy of the Bladder

Case No. 10. This patient had bilateral ureterosigmoidostomies performed elsewhere because of the bladder exstrophy. We first saw this patient a year later because she had not done well following this procedure. An excretory urogram revealed no function of the right kidney and only slight function of the left. A few months later she became stuporous and continued to have recurrent bouts of fever. On admission her CO_2 combining power was 9.8 volume per cent, her serum chlorides were 676 mgm, per cent and blood urea was 96 mgm, per cent. A left nephrostomy was performed and her abnormal blood chemistries returned to normal in four days. She tolerated the nephrostomy well for four months and then each uretero-intestinal anastomosis was explored. A 2 cm. side-to-side anastomosis at the distal end of the right ureter and sigmoid was made without undoing the previous anastomosis. On the left a curved clamp was passed through an opening in the wall of the ureter into the bowel. A stricture at the old anastomosis was forcibly dilated. She has done well the past 15 months on a restricted salt diet, supplemental soda bicarbonate, high fluid intake and intermittent chemotherapy. If she had not done better a permanent colostomy was to be considered. She has gained 20 pounds in fifteen months and has had no bouts of fever. A danger signal the past six months has been a gradual rise in the blood urea and it is anticipated additional surgery will be necessary.

SUMMARY AND CONCLUSIONS



FIGURE 4. A retrograde cystogram in Case No. 7 showing a catheter coiled in a large prostatic urethra, narrowing at the internal sphincter, and trabeculation of the bladder.

catheter coiled in a large prostatic urethra, nar-

A study of 50 children with uncomplicated urinary tract infections is presented. The laboratory findings and the incidence of various signs and symptoms are discussed. A microscopic examination of the urine revealing a pyuria is essential for the diagnosis. A urinary tract infection may cause certain signs and symptoms; an unexplained fever, abdominal pain or tenderness, flank pain or tenderness or bladder symptoms. The finding of albuminuria was not an accurate indication of urinary tract infection in the series.

Ten cases with complicated urinary tract infections are presented. Six female and two male patients had bladder neck obstruction. All eight patients had transurethral resection. One patient had a large ureterocle. One patient with estrophy of the bladder and complications following bilateral uretero-sigmoidostomy completes this group. These cases are presented to show the number of problem cases that have been discovered in a relatively short period of time and to emphasize the value of thorough urological study in children.



FIGURE 5. Case No. 7 following transurethral resection showing the internal sphincter region Avesical neckQ to be wide open.

President's Page

As I enter upon the last half of the year I will be your President, I can truthfully say that my pre-conceived ideas concerning the responsibility of the medical profession in the American way of life have not only been substantiated but magnified and broadened.

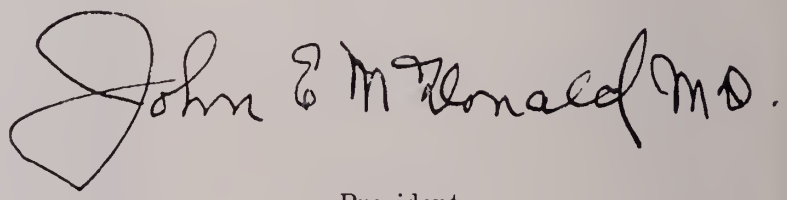
It is virtually impossible for any physician who has not been accorded the honor that has come to some of us to know fully the impact of this responsibility.

As most of us go about our daily work, we realize the extent to which many factors, forces and persons through individual effort or the organizations they represent, are either working for or against the medical profession.

How many of us realize and accept our responsibilities in the problems of Rural Health, School Health, programs such as Diabetes Detection, Cancer, Tuberculosis, Care of the Veterans, Problems of Malpractice, Programs of the Vocational Rehabilitation, Public Welfare Department, Cults, Pre-paid Medical and Hospital Care and many others almost too numerous to mention.

These problems, which are the problems of all of us, are the consideration and the responsibility of the Council and committees of the Association and County Societies, yet all too often the responsibility for the decisions which are made and the actions that are taken fall on the shoulders of a few who are in turn sometimes criticized for their activities in behalf of the economic and social problems of our profession.

As we enter into that time of the year where we set aside a day for Thanksgiving and a day to acknowledge the coming of a Power greater than ours, I should like to say that the strength of our profession as it is put to the use of humanity, will only be as great and as humble as our individual efforts and conscience dictates and the extent to which we place our hope and trust in God.



President



Various factors during pregnancy (intestinal displacement, atony, inactivity) make it virtually impossible for most women to go through the gestation period without constipation.

CONSTIPATION IN PREGNANCY:

Satisfactorily controlled with Metamucil®

Metamucil, with its physiologic principles of "smoothage" and "normohydration," is well tolerated for pregnancy constipation. This bland vegetable colloid may be used throughout the entire nine-month period without fear of forming a "habit" and without irritation to the mucosa.

Greenhill[1] suggests that Metamucil be given every other night. He also recommends that Metamucil be given in conjunction with a proper diet, during the lying-in period of the puerperium.

Metamucil is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

1. Greenhill, J. P.: Principles and Practice of Obstetrics, ed. 10, Philadelphia, W. B. Saunders Company, 1951, pp. 103-104; 311; 332.

SEARLE Research in the Service of Medicine

Special Article

PROGRAM HIGHLIGHTS FROM THE ANNUAL MEETING AMERICAN MEDICAL WRITERS' ASSOCIATION

Mary Lou Crahan
EDITORIAL ASSISTANT

Because of the number of scientific articles that have to be returned to the authors for re-writing and in an effort to cut down the amount of editing done by the *Journal* editorial staff, the Editorial Board requested me to summarize the papers presented at the American Medical Writers' Association annual meeting in Springfield, Ill., September 23.

Pointing out that the average medical student does not have the ability to express himself clearly and concisely in writing, Dean F. Smiley, M.D., editor of the *Journal of Medical Education*, suggested that essay type examinations be given students rather than objective type tests.

Authors preparing papers that will be read mostly by general practitioners were urged by C. W. Schumacher, M.D., editor of *Missouri "G.P.,"* to remember that they are writing for a busy man who must read comprehensive material and that timely, clear cut background information must be given.

Stewart Wolf, M.D., Oklahoma City, speaking on "Writing for the Medical Specialties," told the medical writers in attendance that they have an obligation to the reading public, which editors do not always require, to stimulate a broader view of medicine.

Quoting Sir William Osler, Lee D. Van Antwerp, M.D., editor of the American Medical Writers' Association *Quarterly Bulletin*, said, "An experience or study is not complete until it is written up and published." Asking the group if what medicine has to tell is less important than facts about engineering, he told them that Cornell University engineering students are required to take two courses in English and appealed that the same be encouraged for medical students.

Doctor Van Antwerp's remarks were in line with those made by Lawrence McHenry, junior medical student from Oklahoma City, who recommended a lecture or laboratory course in writing be given at the end of the second year or beginning of the third year. He pointed out that from the beginning, students are not taught an appreciation of writing and that the science of medicine, not the art, is emphasized.

"The Desirability and Methods of Teaching Medical Writing to Senior Medical Students" was the topic discussed by Dr. W. R. Bett of London, England. Doctor Bett told the group that there are more than 4,000 medical publications and that more than one million scientific articles are printed each year. Emphasizing that the first essential of writing is to have something to write about, he gave three rules for good writing: 1. simplicity; 2, accuracy; and, 3, authenticity. He further urged brevity and arrangement and advised that papers should conform to the editorial policy of the journal or periodical selected for possible publication of the article.

Representing the University of Oklahoma Press, Savoie Lottinville, Director from Norman, stressed that adequate communication is absolutely essential in the doctor's transmission of his knowledge, and concluded that men not capable of expressing a technical idea probably do not have the idea themselves.

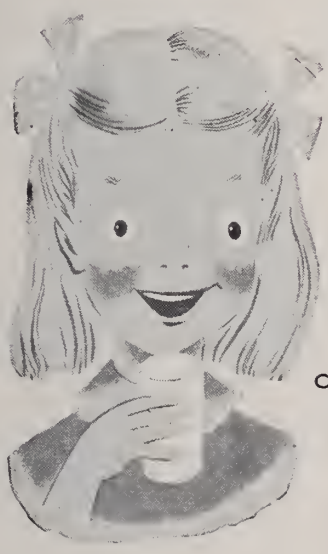
Mrs. Eugenia B. Dabney, Assistant Editor of the *Southern Medical Journal*, suggested that editors of medical journals and authors writing for those journals, abide by the Council on Pharmacy and Chemistry of the American Medical Association in the use of proprietary names in their publications, and Mrs. Ruth Good of the University of Michigan *Medical Bulletin*, pointed out that medical editors are in a particular position to improve medical writing. This was further

(Continued on Page 322)

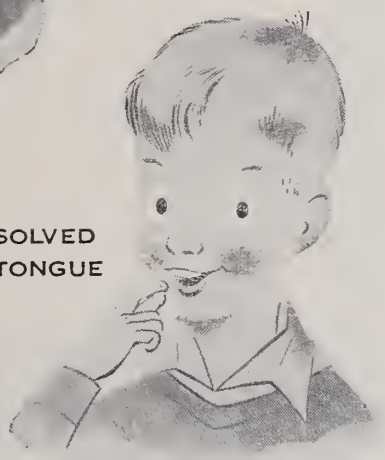


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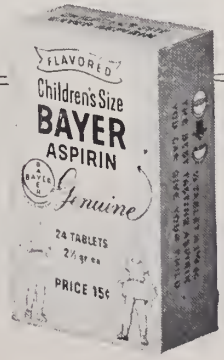


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DOCTOR NIEMANN HONORED WITH PLAQUE FROM CITY

In recognition of his 49 years of medical service in Ponca City, a plaque was recently presented to George H. Niemann, M.D., at the annual Old Settlers luncheon.

Doctor Niemann, who retired in May after a half century of medical practice, came to what was once Cross, now a part of Ponca City, six weeks after the Cherokee Strip land run in 1893. He attended Ponca City schools and in 1900 enrolled at the University of Kansas. He completed his medical training at Northwestern University in 1905 and returned to Ponca City.

Active in civic work, Doctor Niemann is a past president and director of the chamber of commerce and a member and past president of the Rotary Club. He is also a past president of the Kay County Medical Society and served as chief of staff for many years of the Ponca City Hospital.





LIFE MEMBERSHIP, FIFTY-YEAR PIN PRESENTED

Three Oklahoma physicians have recently received 50 Year Pins or Life Memberships in ceremonies conducted by their county medical societies. Charles E. Calhoun, M.D., Sand Springs (story elsewhere on this page), J. L. LeHew, M.D., Pawnee, and G. A. Comp, M.D., Manitou, are the recipients of the honors conferred by the O.S.M.A.

Doctor Comp's pin was presented at a meeting of the Tillman County Medical Society and presentation was made by O. G. Bacon, M.D., Frederick. Doctor Comp, who has practiced in Tillman County since 1906, was graduated in 1903 from the St. Louis College of Physicians and Surgeons. He practiced two years in Edmond immediately after graduating. Still active in general practice, he has delivered more than 2000 babies.

Life membership certificate was presented to Doctor LeHew at a Councilor District meeting by President John E. McDonald. Doctor LeHew, who has practiced medicine more than 50 years, has two sons who are medical doctors and one who is a dentist. They are Elton Lehew, M.D., and J. L. Lehew, M.D., both of Guthrie, and Clifford Lehew, D.D.S., Pawnee.

SAND SPRINGS DOCTOR RECEIVES 50 YEAR PIN

Dr. John E. McDonald, right, President of the Oklahoma State Medical Association, congratulates Dr. Charles E. Calhoun of Sand Springs, Oklahoma, upon the completion of 50 years in the practice of medicine.

Doctor McDonald has just pinned a gold 50-Year Club pin on Doctor Calhoun's lapel. The ceremonies took place at the September 14 meeting of the Tulsa County Medical Society at Children's Medical Center, Tulsa.

Born in 1878, Doctor Calhoun was graduatel from Maryland Medical College in 1903. He entered practice the same year at Shawnee, Oklahoma, and in 1910 moved to Sand Springs. During World War I he served as a lieutenant in the Army Medical Corps.

Above left: Doctor McDonald congratulates Doctor Calhoun. Below left: Doctor LeHew (center) receives his certificate from Doctor McDonald while Mrs. McHew looks on. Below right: Doctor Bacon presents Doctor Comp's pin to him.



SCHOOL CONFERENCE CONSIDERS HEALTH PROBLEMS

C. M. Bielstein, M.D., Oklahoma City, presented the film "School Health in Action" at the fourth National Conference on Physicians and Schools, held in Highland Park, Ill., September 30—October 2.

Nearly 200 physicans, public health officials and educators participated in round-table discussions at the conference, sponsored by the American Medical Association's Bureau of Health Education. Thirty-eight states and the District of Columbia were represented by delegates from state departments of health and education, state medical societies and national health organizations.

Dr. Edward J. McCormick, Toledo, O., resident of the American Medical Association, reported that accidents were the greatest hazards of childhood, killing more than 14,000 children annually. This toll, Dr. McCormick said, was more than the combined mortality from the next six main causes of deaths in children—pneumonia, congenital defects, cancer, tuberculosis, leukemia and heart disease.

He pointed out that the combined efforts of medical and lay groups already have been rewarded by reducing child mortality more than 50 per cent in the last 15 years. He predicted a further decrease.

Creation of advisory school health councils as a means of best meeting the health needs of children was urged by a discussion group headed by Dr. John W. Shackelford, Oklahoma City, director of local health service for the Oklahoma Department of Health. Such a council should be made up of representatives of all segments of the community, it was emphasized.

BLUE CROSS PHYSICIAN ENROLLMENT IS LOW

The recent enrollment of physicians in Blue Cross was disappointing in regard to the total number who availed themselves of the opportunity to take out Blue Cross hospitalization.

Although ads were run in the Journal and direct mailings were sent to all members of the Association, only 69 physicians, not previously covered through their own group, took advantage of this enrollment opportunity.

Those physicians who did not enroll by October will not have another opportunity until the next anniversary date of the group which will be October 1, 1954.



Doctor Niemann (center) displays his plaque. Pictured with Doctor Niemann are E. C. Mohler, M.D., C. E. Northcutt, M.D., Ponca City Chamber of Commerce President J. C. Hampton, and Felix C. Duvall.

OBITUARIES

WILLIAM C. McCLURE, M.D.

1909-1953

William C. McClure, M.D., Oklahoma City, was killed in an automobile accident near Amarillo, Texas, September 24.

Doctor McClure, an assistant professor at the University of Oklahoma School of Medicine, received his degree there in 1936. He practiced in Boston, Mass., until 1939 when he moved to Oklahoma City. During World War II he served with the marines in the Pacific and was awarded the Bronze Star and Purple Heart.

He was active in a number of medical organizations and the amateur radio club.

Survivors include his parents, Mr. and Mrs. John C. McClure, Oklahoma City, and two sisters.

G. G. HARRIS, M.D.

1887-1953

George G. Harris, M.D., Helena, died September 30 while making a call in Enid.

Doctor Harris, who had practiced medicine in Helena since 1927, was born in Dallas. He graduated from the University of Oklahoma School of Medicine in 1917 and served in the medical corps in World War I.

He was active in medical organizations and also belonged to the Masons, the Helena Chamber of Commerce, and the Christian church.

He is the father of Lillian Robinson, M.D., Enid, and is also survived by the widow of the home, a son, foster-daughter, brother, two sisters and five grandchildren.

HOSPITAL GROUP THEME IS ACCREDITATION

The Oklahoma State Hospital Association emphasized "Accreditation" at its annual convention which convened at the Hotel Mayo, Tulsa, Oklahoma, November 12 and 13. With the formation of the Joint Commission on Accreditation there has been renewed interest throughout the State of Oklahoma among medical staff members since accreditation, in effect, revolves around medical practice within the hospital.

Dr. John Hinman, Assistant Director of the Joint Commission on Accreditation, outlined the program of the Commission. A field representative of the Joint Commission on Accreditation conducted an actual survey staff member, a hospital trustee, a hospital administra- of a fictitious hospital with the assistance of a medical tor, a director of nurses, and a medical record librarian.

MALPRACTICE JUDGMENT AFFIRMED BY COCRT

The Supreme Court recently reaffirmed its previous opinion awarding a plaintiff $60,000 in damages against a Tulsa physician.

The suit against the physician was not for malpractice but for assault having as the basis the giving of a spinal anesthetic.

MEDICAL HISTORY IN OKLAHOMA . . . A PROGRESS REPORT

Your committee is pleased to report that there has been no let up in the pursuit of historical data even during the hot summer. The results of our field workers carried on with funds appropriated by the State Medical Association are very encouraging. It now appears that we may be able to build up a formidable backlog for the medical historian or the advanced scholar who wants to prepare theses on some phase of medical history.

At the last Council meeting, James M. Babcock and your committee chairman made a brief progress report and the Council authorized an additional appropriation of $1,500.00.

It is hoped that this will keep a young man in the field until the whole state has been covered by this first rather comprehensive survey. In addition to the material accumulated by this survey many valuable leads are being discovered. These leads offer much valuable material and the work must go on until every possible source has been explored. The enthusiasm and cooperation we are receiving from the University is most gratifying.

Evidence of this appears in the following letters addressed to the chairman of the committee expressing appreciation of the Council's recent generous gesture:

"Jim Babcock told me about the check in the amount of $1500 which you delivered to him to be spent in collecting archival material having to do with the history of medicine in the State of Oklahoma. I know that Mr. Babcock has already expressed to you his appreciation of your fine efforts in regard to this project, but I wanted to tell you personally how much I appreciate this fine aid. It would be impossible for the Department of Archives to really get the job done without help of this kind. Thank you very much indeed.

Sincerely yours,
s/G. L. Cross
President
University of Oklahoma"

"I want to take this opportunity to add my own thanks and appreciation to those which Mr. Babcock has already expressed for the additional grant of $1,500 by the Oklahoma State Medical Association to the Manuscripts and Archives Division of the University Library, for the continued collecting of manuscript materials having to do with the history of medicine in Oklahoma. Will you please convey to the Oklahoma State Medical Association my warm thanks on behalf of the University Libraries?

"We are pleased indeed that the Manuscripts and Archives Division has the opportunity to participate in this project. It is not only most desirable and beneficial today, but this value and usefulness will increase over the years. The Association is thus making possible a present-day service to Oklahoma and to the medical profession in Oklahoma, and this service also has the unusual property of becoming even more valuable with the passage of time.

Cordial best regards,
Sincerely yours,
s/Arthur McAnnally
Director of Libraries
University of Oklahoma"

"This is to gratefully acknowledge receipt of the additional grant of money from the Oklahoma State Medical Association for the purpose of continuing the program of collection and preservation of the medical archives of Oklahoma.

"The field staff of the University Library's Division of Manuscripts has covered almost the entire eastern half of the state in search of medical records. In the course of this survey nearly 300 individuals have been interviewed and more than 65 collections received.

"Also many leads to other materials have been obtained through responses to articles, released by the Public Relations Bureau of the University and published by local newspapers over the state.

"Everyone contacted in connection with this program has been most cooperative in every way. It is gratifying to find such an awareness of the importance of the preservation of medical archives.

"The University under terms of the grant will continue to work toward a complete and systematic survey of the state to locate and negotiate for transfer to the Archives, all materials reflecting the history of medicine.

Yours truly,
s/James M. Babcock
Acting Archivist"

In addition to the above activities, the Committee wishes to report that on funds independent of the State Medical Association appropriations, a research worker in Washington, D. C. is searching the archives of the War Department, the Department of the Interior and the Indian Commission for authentic data on Indian medicine on the plains and the pre-territorial "white man's" medicine as practiced and experienced in this area.

This report is being published by your Committee with the hope of approval and further support by the membership and the Association.

History of Medicine Committee
Ralph McGill, M.D.
T. H. McCarley, M.D.
John Carson, M.D.
Lewis J. Moorman, M.D., Chm.

HISTORY OF MEDICINE PROJECT GROWING

More than 50 Oklahoma physicians or their families already have made valuable contributions to the medical archives being collected at the University of Oklahoma.

One of the most interesting collections was given by Mrs. Ethel Johnson, McAlester, daughter of the late Dr. Alfred Griffith, McAlester. This included his dairies and journals dated 1865 to 1882, correspondence from 1865 to 1915, and his appointment as a Civil War surgeon.

Another noteworthy gift was a manuscript of "Experiences of a Pioneer Physician in Indian Territory" given by its author, Dr. V. Berry, long-time Okmulgee doctor.

Early-day surgical instruments also have been collected, and will be displayed in the OU Museum, while other material will remain at the Bizzell Memorial Library on the main campus.

Collections are being made by the archives department of the OU library under the sponsorship of the Oklahoma State Medical Association.

When the records are assembled, a history of medicine in Oklahoma will be written. The goal of those working on the program is to obtain a collection on every doctor in Oklahoma. This consists of a photograph and biographical data, plus other materials. Also being saved are records of clinics and hospitals.

Directing the task is James M. Babcock, acting archivist. Assisting is Hugh Cunningham, OU graduate from Kingfisher, who replaced Jack Saunders, Norman, when he entered service.

Collection work started June 1. Contributions so far run the gamut from a single newspaper clipping from one early-day physician to two station wagon loads of material from another doctor.

The medical treasure hunt has taken Babcock and his assistants on field trips through southeastern Oklahoma this summer. They now plan visits to other parts of the state.

They have scoured attics, basements, closets, storage rooms and garages. They have interviewed doctors and their families in farm homes, city residences, clinics, hospitals and offices.

What are they looking for? Briefly, they want medical records, files, papers and reports of doctors' work, professional associations and writings. Donations include diaries, letters, ledgers, scrapbooks, surgical instruments, membership lists and photographs.

Donations may be preserved in the original, or in photocopies or sound recordings.

Importance of the research work was emphasized by Dr. M. L. Wardell, OU history professor and author.

"The problem of collecting archives in the field of medicine can be solved only with the cooperation of those persons now practicing medicine, the members of families of those who have died, and any other persons who may have access to documents pertaining to medicine," Doctor Wardell stated.

"Once the job of collecting has been completed," added Babcock, "a competent researcher can begin writing the story of Oklahoma medicine."

Attention

The Cardiovascular Section of the Oklahoma Medical Research Foundation has been studying the lipid and lipoprotein disturbances in a patient with primary xanthomatous bilary cirrhosis utilizing ultra centrifuge and electrophoresis techniques. Results to date have been most interesting and many reveal for the first time a fundamental lipid-protein disturbance. It is highly desirable that further observations be made in other patients with biliary cirrhosis of any type. Physicians knowing of such patients whom they would consider as possible candidates for either in-patient or out-patient studies are urged to get in touch with Robert H. Furman, M.D., 825 N.E. 13th St., Oklahoma City 4, Oklahoma.

FUNDS GIVEN FOR HISTORY OF MEDICINE

An additional $1,500.00 has recently been presented to the Department of Archives of the University of Oklahoma by the Oklahoma State Medical Association. The check was to complete the field work in the assembling of medical history.

Anyone having knowledge of any history through either living physicians or families of deceased physicians is asked to contact Lewis J. Moorman, M.D., Chairman of the Association History of Medicine Committee, 1227 Classen Drive, Oklahoma City.



Pictured above is the Tulsa County Medical Society Exhibit placed in a downtown Tulsa show window as part of Tulsa Progress Week, a promotion of the Tulsa Chamber of Commerce illustrating the progress of the city in the last 50 years. Some 40 firms and industries prepared exhibits. The Medical Society exhibit was in the Fred Jones Ford Company show window and pictured a mannequin dressed in 1903 clothing representing a doctor of that era and placed beside a vintage Ford. In contrast, a second mannequin was dressed to represent the 1953 doctor and placed beside a 1953 model Ford. Three large posters contained comparative medical statistics.

POSTGRADUATE COURSES ANNOUNCED BY SCHOOL

SURGERY—December 9, 10 and 11

Time will be divided between subjects of special interest to the general practitioner and those more advanced problems of interest to the general surgeon. Contributions by three guest instructors and the staff of the Department of Surgery will provide the registrants with a good opportunity to develop a wider knowledge in surgery and surgery techniques.

PSYCHIATRY—December 28 and 29

The Department of Psychiatry and Neurology and the Mental Hygiene Division of the State Department of Health will conduct a course in Psychiatry and Neurology. Instruction will be in these fields as well as in associated medico-legal problems. Three physicians of national reputation will participate in the course.

OBSTETRICAL-GYNECOLOGICAL SOCIETY—Jan. 16

The Oklahoma City Obstetrical and Gynecological Society with the cooperation of the State Department of Health and WKY-TV will hold its annual program and meeting. As in the past the time will be divided between televised operations and demonstrations and lectures featuring a prominent leader in the field of Obstetrics and Gynecology. That evening there will be a social gathering and dinner for the members, the registrants and their wives.

PEDIATRICS—January 28, 29 and 30

The Department of Pediatrics, the Maternal and Child Health Division of the State Department of Health, and the Oklahoma State Chapter of the American Academy of Pediatrics are developing a pediatric program pertaining to problems of the behavior aspects of pediatrics and the prevention of rheumatic fever.

MARCH OF MEDICINE TELEVISED IN STATE

Designed to create better understanding by the public of some of our major health problems, and to portray the extent of research being carried on by the medical profession, a total of 73 stations of the NBC-TV network are carrying the new "March of Medicine" program. Sponsored by the American Medical Association and Smith, Kline and French Laboratories, the program is carried from 10:30 to 11:00 p.m. on WKY-TV, Oklahoma City, and over KOTV-TV, Tulsa, at 10:30 p.m.

The November 25 WKY and November 18 KOTV program will report on cancer research. The December 23 WKY and December 16 KOTV program will present highlights of the A.M.A. meeting in St. Louis.

ANNOUNCEMENT

The University of Kansas School of Medicine is presenting a refresher course in MEDICAL TECHNOLOGY, JANUARY 11 to 13, inclusive, at K.U. Medical Center, Kansas City, Kansas. An annual event, the course consists of lectures, discussions and demonstrations by outstanding teachers, covering a wide variety of subjects of timely and vital interest to the technologist. Panel discussions at the close of each day's program provide the enrollee an opportunity to have additional subjects or laboratory techniques of special interest to him discussed by an outstanding faculty group.

The course is open to all serving in medical laboratories, whether registered technicians or not, upon payment of the $12.00 enrollment fee. The program announcement is available on request.

ELECTROCARDIOGRAPHY—March 1 Thru March 6

The course consists of informal lecture presentations which assume no formal acquaintance with the subject and which emphasize the physical basis of the subject. Laboratory exercises are carried out by the participants with individual help from the instructors. All working materials are furnished including a lecture notebook with figures and ECG's to eliminate note taking and permit study in advance of lectures. Participants are expected to attend all lectures and laboratory periods and remain the entire time scheduled.

GENERAL SURGERY—March 2

A series of 10 consecutive Tuesday evening surgery conferences will be organized by the Department of Surgery. Staff memmers of the Medical Center will be the instructors.

EYE, EAR, NOSE AND THROAT—March 26

The Oklahoma Academy of Ophthalmology and Otolaryngology have chosen this day for their annual course and meeting. An interesting program is planned in the morning featuring as guest instructors Doctor Chandler, Opthalmologist of Boston, Massachusetts and Doctor Theodore Walsh, Otolaryngologist of St. Louis. That evening there will be a dinner meeting followed by a paper given by each of the guest instructors. Registration will be limited to Opthalmologist and Otolaryngologists and their guests.

TRAUMA—April 2 and 3

A postgraduate conference on Trauma will be sponsored by the Department of Orthopedic and Fracture Surgery.

INTERNAL MEDICINE—April 7, 8 and 9

A three day course is scheduled by the Department of Internal Medicine. Problems of wide interest in the field of Internal Medicine will be stressed and the program will be highlighted by guest instructors from other medical centers. This course will be of great benefit to those in the field of internal medicine as well as to the general practitioners.

RADIOLOGY—May 7 and 8

The Department of Radiology will conduct a refresher coursre in Radiology.

RECEIVE INTERNATIONAL COLLEGE OF SURGEON HONORS

Eleven Oklahomans were in the 18th Annual Convocation Class of the Canadian and United States sections of the Internationaol College of Surgeons held September 17 at Carnigie Hall, New York. They are:

Robert C. Feamster, M.D., McAlester, Qualified Fellow

Russell D. Harris, M.D., Oklahoma City, Qualified Fellow

Claran Henry Jesse, M.D., Ardmore, Qualified Fellow

Charles M. O'Leary, M.D., Oklahoma City, Qualified Fellow

William G. Peterson, M.D., Ada, Qualified Fellow

Fred T. Fox, M.D., Lawton, Associate

Gilbert L. Hyroop, M.D., Oklahoma City, Associate

John B. Miles, M.D., Anadarko, Associate

Warren B. Poole, M.D., formerly of Oklahoma City and now of Lubbock, Texas, Associate

C. A. Traverse, M.D., Alva, Associate

Robert W. Gibson, M.D., Ponca City, Junior Member, and

Joseph L. Spann, M.D., Tulsa, Junior Member.

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FIRST RURAL HEALTH CONFERENCE IS SUCCESS

The role of the Auxiliary in promoting rural health was emphasized by Mrs. Charles W. Sewell, former director of the Associated Women, American Farm Bureau Federation, when she addressed the first Oklahoma Rural Health Conference held in Oklahoma City September 8 and 9. Mrs. Sewell was speaker at the luncheon and her topic was "Let's Do It Ourselves."

Approximately 200 leaders representing farm groups, P-TA, medicine and allied groups registered at the conference which opened with a tour of the Oklahoma Medical Research Foundation.

Following a general session in which the plan of the conference was outlined by R. C. Emmott, M.D., Stillwell, chairman of the program committee, those in attendance joined the smaller discussion groups of their choice. Topics listed below were presented:

1. "Organizing Rural Communities to Meet Their Own Health Needs," David Steen, Norman, executive secretary, Oklahoma Advisory Health Council; and Milton Johnson, Oklahoma City, health educator, Oklahoma State Department of Health.

2. "The Periodic Physical Examination and Rural Health," Kirk T. Mosley, M.D., Oklahoma City, director of the division of chronic disease, State Health Department, professor, preventive medicine, University of Oklahoma School of Medimines; and Harry A. Daniels, M.D., Oklahoma City, chairman of the O.S.M.A. education committee.

3. "Nutrition and its Realtion to Rural Health in Oklahoma," Miss Veda Bailey, Oklahoma City, Wesley Hospital dietitian; and Robert MacVicar, Ph.D., Stillwater, dean of the graduate school at Oklahoma A. and M. College.

4. "Animal Diseases and Their Relation to Rural Health in Oklahoma," J. Wiley Wolfe, D.V.M., school of Veterinary Medicine at A. and M.; and Leon C. Freed, M.D., Perkins.

5. "Meeting the Costs of Medical Care of Oklahoma's Farm Families," Wayne Starkey, M.D., Altus, member of the Blue-Shield Board of Directors; and Alton Reid, Altus, hospital administrator.

6. "How Rural Oklahoma Communities Can Get Physicians," Dick Graham, O.S.M.A. Executive Secretary; and Tullus Looney, Boise City.

Speaker at the dinner was Aubrey Gates, Little Rock, Arkansas, field director of the A.M.A. Council on Rural Health, who spoke on "Rural Health is Your Business." Mr. Gates pointed out that health is a personal responsibility, and further emphasized the need for more health education stressing the advantages of rural health conferences whereby farm, extension, business and related groups could meet with the medical profession and work out solutions to present rural health problems.

Conference sponsors, in addition to the State Medical Association, were the Oklahoma Farm Bureau Federation, Oklahoma State Dental Association, Oklahoma State Health Department, Oklahoma Home Demonstration Council, Oklahoma Advisory Health Council, Oklahoma Congress of Parents and Teachers, and the Extension Services of the University of Oklahoma and Oklahoma A. and M. College.

HAVE YOU HEARD?

Howard A. Bennett, M.D., Oklahoma City, was a member of the program committee for the American Society of Anesthesiologists annual meeting held October 5-9 in Seattle, Washington.

Charles A. Smith, M.D., announces the opening of his offices at the Lockett Hotel, Norman, for the practice of neuropsychiatry.

O. A. Pierson, M.D., Woodward, recently celebrated his 86th birthday.

F. L. Wormington, M.D., Miami, was presented a 50 Year membership pin by the Miami Masonic lodge.

Alfred B. Hinkle, M.D., University of Oklahoma School of Medicine graduate who recently completed a year's internship at the Gorgas hospital, Panama Canal Zone, is now practicing in Alva.

Leslie T. Hamm, M.D., Lawton, has been named chief of staff of the Comanche County hospital.

W. P. Lerblance, Jr., M.D., and *David C. Clemens, M.D.*, have opened the Twin-Cities clinic in Hartshorne.

Edward C. Reifenstein, Jr., M.D., formerly of Oklahoma City, has been appointed director of th biological and therapeutic research division of Schering Corporation, Bloomfield, New Jersey.

Henry H. Turner, M.D., Oklahoma City, attended the advanced course in the use of isotopes in medicine given by the Atomic Energy Commission at Oak Ridge, Tennessee, during September. He also presented two lectures before the Texas Academy of General Practice September 23. They were entitled "Endocrine Disorders of Childhood," and "Psychosomatics and Pseudoendocrinopathies." Doctor Turner gave a series of six lectures on endocrinology in Bogota, Colombia, in October and he and Mrs. Turner returned to Oklahoma City by way of Atlanta, Georgia, where he attended the meeting of the Southern Medical Association. Doctor Turner is the new Councilor from Oklahoma to the S. M.A.

(Continued from Page 314)

emphasized by James C. Leary, director of public relations of the Illinois State Medical Society, who suggested that editors demand higher standards for their medical journals, thereby encouraging higher standards in the preparation of papers for the journals.

Others who made valuable contributions to the program were Theodore R. Van Dellen, M.D., medical editor of the *Chicago Tribune* who spoke on "Writing for the Public by the M.D.;" Richard M. Hewitt, M.D., of the Section on Publications, Mayo Clinic, who was a discussion leader; and Russell L. Drake, also of Mayo's, who gave the viewpoint of a medical illustrator.



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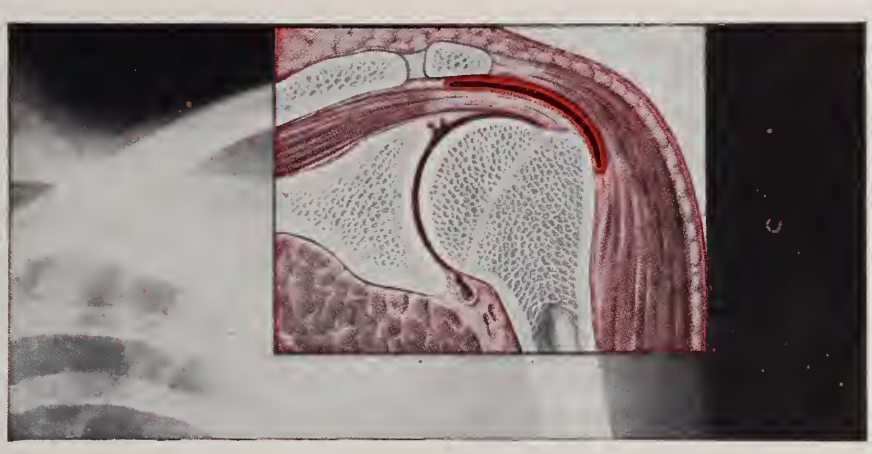
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Book Review

SEXUAL BEHAVIOR IN THE HUMAN FEMALE. Alfred C. Kinsey, Wardell B. Pomeroy, Clyde E. Martin, and Paul H. Gebhard. Philadelphia and London, W. B. Saunders Company, 1953.

This is not strictly a review of the book popularly known as the Kinsey Report, but rather a series of reactions caused by a careful reading of the book from cover to cover. These reactions are colored by more than 50 years experience with sexual behavior as it appears in the daily routine of the family physician.

My first reaction poses this pertinent question: Acknowledging the sincerity of the authors and the enormous expenditure of effort and money, can the publication in the hands of the public accomplish any good purpose? This question demands serious consideration from everyone who reads, even though the reading is spurred by mere curiosity.

The book is admittedly a progress report. In the field of science, progress is reported to those interested in the particular problems under consideration. The purpose of such a report is to set forth findings, probabilities and obstacles. This is done with a full knowledge of the fact that many projects with promising progress reports never come to full fruition. It is understood that reporting for publication before final conclusions are reached is a hazardous procedure. In this case it seems most unfortunate. But the report is already in print, therefore, it is well to stress its limitations and its harmful possibilities.

My second reaction is based upon the fact that sexuality is one of the deep mysteries in the incomprehensible cycle of our existence and in all probability should be let alone. To all worthy individuals, sexuality stands among the sacred gifts of creation. In normal individuals, it functions spontaneously with personal aspirations and satisfactions not to be shared with the curious world about us. Is it not possible that our innate, instinctive sexuality under individually acquired inhibitions will pursue its uncharted course regardless of Kinsey's report whether it is complete or incomplete.

Even the lower animals know enough to reproduce their kind. If additional knowledge were possible, could it improve on this perfect performance? The adequacy of the human female's sexual behavior is convincingly demonstrated by the newborn babe in its mother's arms. Who can fathom the creation and the evolution of life, the mystery of love and motherhood. Strange to say, these fundamental factors so intimately identified with sex find no place in this report. No one would expect Kinsey to explain these remarkable phenomena but their influence on sexual behavior cannot be ignored.

This from Amram Scheinfeld, September, 1953, *Cosmopolitan*, quoted in October, 1953, *Readers Digest* is interesting in this connection. Flying back from Indiana where he had inspected the Kinsey material, across the aisle he observed a young G. I. and his wife with their baby and this is what he wrote: "The soldier was fast asleep. So was the baby, nestled in its mother's arms. But the young woman was dreamily awake, her head had snuggled against her husband's shoulder, and I watched her eyes look up at him adoringly, then move down to her baby, then back to her husband again.

"It came to me, suddenly, what was lacking in the Kinsey treatise. Among all the hundreds of pages of statistics, tables and text, dealing in such detail with 'premarital and marital coitus,' 'petting,' 'adultery,' and so on, I could recall seeing nothing about two experiences which, one would certainly suppose, have a great deal to do with a woman's sexual behavior: motherhood—and love."

My third reaction is engendered by a feeling that the contents of the report seem never to rise above the animal level. With a medical knowledge of women and their sexual behavior, this appears to me as an insult to all self-respecting American women who must mother a great nation.

This report emanates from the Department of Zoology, University of Indiana. Though the study has attempted to move us up through the sexual behavior of insects and animals to that of women, the authors have failed to classify woman as the superior being that she is. Since our unicellular existence we have sloughed off a lot of slime. Somewhere in the course of evolution certain creative forces sparked our consciousness of environment with the gift of reason and through the development of self-consciousness our faces were lifted from the earth and we became superior to the animals and intellectually we were able to transcend the physical bounds of environment.

Groping for an anchor outside ourselves, we conceived the supernatural. Through spiritual values, we developed the concepts of right and wrong and the gradual growth of inhibitions to help keep us in line for higher and better living. Thus we experienced a self induced moral evolution toward what we are pleased to call civilization. This self imposed discipline, born of our inhibitions, has suffered a serious let down because of two world wars, the John Dewey philosophy of education and the changing pattern causing parents and teachers to encourage uninhibited self expression. No doubt much of the juvenile delinquency may be attributed to the fact that many character building inhibitions have been discarded. This moral and spiritual retrogression appears in the reported comparison of sexual behavior before and after the turn of the century.

Unfortunately, throughout the report, one gets the implied suggestion that sexual behavior would be more natural and more satisfying if it were not for religious beliefs and other inhibiting influences. This is regrettable because such inhibitions have served as stepping stones to higher planes of living.

For reasons already given, we believe the statistics are not representative with reference to the incidence of indulgence, especially in the matter of coitus, at the various age periods. This is not in criticism of the reporting but implies the interviewing of too many of the wrong people. In other words, the report does not represent an equable cross secton of the American female population.

In the chapter on extra-marital coitus we find the implication that promiscuity may be justifiable because it may lead to new, exciting experiences with satisfactions not always found at home. The report indicates that such promiscuous sexual behavior seldom causes

trouble unless the husband finds it out. It is not too wrong if it can be concealed. This is much like the bank robber's profligate spending of ill gotten coin. From his point of view he suffers no ill effects until apprehended by the law. The following is lifted from this chapter:

"There are strong-minded and determined individuals who can plan and control their extra-marital relationships in such a way that they avoid possible ill consequences. In such a case, however, the strong-minded spouse has to keep his or her activity from becoming known to the other spouse, unless the other spouse is equally strong-minded and willing to accept the extra-marital activity."

There is not much satisfaction in the authors' admission that "such persons do not constitute a majority in our present day social organization." We would like to have their definition of a strong mind. Is it good to have our young married people classified as weak minded if they do not participate in promiscuous sexual relations with the so-called strong-minded?

The reported desirability of "rapport" intrigues me. It is difficult for me to imagine a state of "rapport" between the good American women I know and a perfect stranger seeking to unveil her sexual behavior, even though he presented ample credentials. I have sat in on many sexual behavior conferences but never uninvited. It appears that the workers have accumulated much information through sex diaries and sex calendars. It is my opinion that normal women do not cut a notch on the rolling pin every time they reach "orgasm" or mark the calendar every time they achieve "total outlet."

My final reaction prompts me to emphasize the fact that the book should not have been published for popular distribution especially as it must be considered a progress report. As presented in its present form it places the self respecting, law abiding, religiously inclined individuals, especially the youth, consciously in the minority group and encourages them to spank their religious and moral scruples into a state of shameful acquiescence. This heads us back toward the behavior of the primitive man who is only once removed from life groping in slime.

There is much in the book, especially in the chapters appearing in Part III, for physicians, nurses and social workers. But granting that possibly here is a part of the stuff out of which scientific conclusions ultimately may come, theer is no good reason to place it before the public. —Lewis J. Moorman, M.D.

A.M.A. CLINICAL SESSION SLATED FOR ST. LOUIS

November 1 has been named as the closing date for hotel reservations for the A.M.A. Seventh Clinical Session to be held in St. Louis December 1-4.
stetries and gynecology, pulmonary diseases, orthopedics and surgery.

Attention will be focused upon the diseases and conditions most frequently met by the general practitioner with a well balanced program of related lectures and clinical conferences to be featured.

Sessions will be held in Kiel Auditorium which is easily accessible to a large number of hotels.

Morning and afternoon programs will consist of general meetings, clinical conferences and six simultaneous sessions, each 30 minutes in length. Main subjects on the program are: neurology and psychiatry, arthritis, dermatology, gastro-intestinal diseases, pediatrics, ob-

CLINICAL SOCIETY WELL ATTENDED

Excellent attendance was reported for the 23rd annual fall conference of the Oklahoma City Clinical Society held in Oklahoma City October 26-29, at the Biltmore Hotel.

Edward M. McCormick, M.D., President of the American Medical Association, was speaker at the dinner. Other speakers included:

H. Davis Chipps, M.D., Director of Laboratories, Ochsner Clinic and Foundation Hospital, New Orleans, La.; Edward L. Compere, M.D., Professor of Bone and Joint Surgery and Chairman of Department, Northwestern University Medical School, Chicago, Ill.; Murray M. Copeland, M.D., Professor of Oncology, Georgetown University Medical Center, Washington, D. C.; Charles C. Dennie, M.D., Professor of Dermatology, University of Kansas Medical School, Kansas City, Kansas; William S. Fields, M.D., Professor of Neurology, Baylor University College of Medicine, Houston, Texas; Erle Henriksen, M.D., Clinical Professor of Gynecology, University of Southern California Medical School, Los Angeles;

W. Paul Holbrook, M.D., Director of Research, Southwestern Clinic and Research Institute, Inc., Tucson, Ariz.; William G. Leaman, M.D., Professor of Medicine and Chairman of Department of Medicine, Woman's Medical College of Pennsylvania, Philadelphia, Penna.; Lyman Mason, M. D., Clinical Professor of Obstetrics and Gynecology, University of Colorado School of Medicine, Denver, Colo.; George Piness, M.D., Associate Professor of Medicine, University of Southern California, Los Angeles, Calif.;

Merrill J. Reeh, M.D., Assistant Clinical Professor and Consultant in Ophthalmic Pathology, Oregon Medical School, Portland, Oregon; Peter A. Rosi, M.D., Associate Professor of Surgery, Northwestern University, Professor of Surgery, Cook County Graduate School of Medicine, Chicago, Ill.; Francis E. Schwentker, M.D., Professor of Pediatrics, Johns Hopkins, Baltimore; Howard E. Snyder, M. D., Lecturer in Surgery, University of Kansas Medical School; and Harry M. Spence, M. D., Clinical Professor of Urology and Chairman of Dept. of Southwestern.

RELEASED FROM SERVICE ON ACTIVE DUTY

Six Oklahoma physicians have recently been released from service according to information received in the Executive Office. They are:

Eugene H. Arrendell, (Lt.) Ponca City, from M.C. A.S., El Toro, Calif., September 1, 1953.

Charles L. Freede, (Capt.) Oklahoma City, from Camp Hood, Texas, September 1, 1953.

Davis C. Ramsey, (Capt.), Ada, from Camp Carson, Colo., August 30, 1953.

H. V. L. Sapper, (Capt.) Oklahoma City, from Fort Knox, Kentucky, September 19, 1953.

Richard J. Schneble, (Capt.) Ponca City, from Bremerhaven, Germany, September 24, 1953.

M. H. Wright, (Lt.) Oklahoma City, from U. S. Naval Hospital, Midway Island, September 4, 1953.

ON ACTIVE DUTY

One Oklahoma physician recently entered active service. He is:

Ralph E. Meinhardt, (Lt.) Oklahoma City, September 7, 1953.

OKLAHOMA STATE MEDICAL ASSOCIATION

1953 COUNTY MEDICAL SOCIETY OFFICERS

SOCIETY	PRESIDENT	SECRETARY
Alfalfa	John X. Blender, M.D., Cherokee	N. L. Morgan, M.D., Cherokee
Atoka-Bryan-Coal	LeRoy L. Engles, M.D., Durant	S. L. Whitely, M.D., Durant
Beckham	O. C. Standifer, M.D., Elk City	James Parker, M.D., Elk City
Blaine	John F. DeJarnette, Jr., M.D., Geary	Virginia Curtin, M.D., Watonga
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Carter-Love-Marshall	Lloyd L. Long, Jr., M.D., Ardmore	Ray B. Graybill, M.D., Ardmore
Cherokee		
Cleveland-McClain	Charles A. Smith, M.D., Norman	F. C. Buffington, M.D., Treas., Norman Jim Haddock, M.D., Sec., Norman
Comanche-Cotton	Robert P. Dennis, M.D., 608½ "C" St., Lawton	L. M. White, M.D., 614 "C" Ave., Lawton
Creek	D. L. McAllister, M.D., Bristow	Charles Kent, M.D., Bristow
Custer	J. Harold Tisdal, M.D., Clinton	Glenn F. Dewberry, M.D., Clinton
East Central	E. Halsall Fite, M.D., 433 N. 16, Muskogee	D. Evelyn Miller, M.D., Memorial Station, Muskogee
Garfield-Kingfisher	Hope S. Ross, M.D., Enid	Roscoe C. Baker, M.D., Enid
Garvin	Morton E. Robberson, Jr., M.D., Wynnewood	Hugh H. Monroe, M.D., Pauls Valley
Grady	R. G. Stoll, M.D., Chickasha	Charles G. Ohl, M.D., Chickasha
Grant	R. W. Choice, M.D., Wakita,	F. P. Robinson, M.D., Pond Creek
Greer	Van S. Parmley, M.D., Mangum	J. B. Hollis, M.D., Mangum
Hughes	V. W. Pryor, M.D., Holdenville	H. V. Schaff, M.D., Holdenville
Jackson	J. H. Abernathy, M.D., Altus	E. W. Mabry, M.D., Altus
Jefferson	W. A. Heflin, M.D., Ryan	O. J. Hagg, M.D., Waurika
Kay-Noble	R. R. Kinsinger, M.D., Blackwell	Bill Simon, M.D., Perry
Kiowa-Washita	L. G. Livingston, M.D., Cordell	
LeFlore-Haskell	G. M. Hogaboom, M.D., Heavener	Neeson Rolle, M.D., Poteau
Lincoln		Ned Burleson, M.D., Prague
Logan	Phillips R. Fife, M.D., Guthrie	J. E. Souter, M.D., Guthrie
Northwestern	J. J. Smith, M.D., Shattuck	Myron C. England, M.D., Woodward
Okfuskee	N. E. Gissler, M.D., Okemah	M. L. Whitney, M.D., Okemah
Oklahoma	Walter H. Dersch, M.D., Medical Arts Bldg., Oklahoma City	Bert E. Mulvey, M.D., Pasteur Bldg., Oklahoma City
Okmulgee	C. E. Smith, M.D., Henryetta	S. B. Leslie, M.D., Okmulgee
Osage		Mrs. Rae Jackson, Ex. Sec'y, Pawhuska
Ottawa-Craig	H. W. Wendelken, M.D., Miami	John E. Highland, M.D., Miami
Payne-Pawnee	D. W. Humphreys, M.D., Cushing	W. O. Davis, M.D., Cushing
Pittsburg	R. A. Harkins, M.D., McAlester	H. C. Wheeler, M.D., McAlester
Pontotoc	George K. Stephens, M.D., Ada	E. M. Gullatt, M.D., Ada
Pottawatomie	James D. Loudon, M.D., Shawnee	Clinton Gallaher, M.D., Shawnee
Rogers-Mayes	W. A. Anderson, M.D., Claremore	Warren G. Gwartney, M.D., Pryor
Seminole	Claude B. Knight, M.D., Wewoka	Andy N. Deaton, M.D., Wewoka
Stephens	B. O. Young, M.D., Duncan	Bill Cheatwood, M.D., Duncan
Texas-Cimarron		James Morgan, M.D., Guymon
Tillman	James Holman, M.D., Tipton	L. O. Short, M.D., Frederick
Tri-County	Floyd Waters, M.D., Hugo	T. E. Rhea, M.D., Idabel
Tulsa	John G. Matt, M.D., Medical Arts Bldg., Tulsa	W. R. Turnbow, M.D., 3015 E. 15, Tulsa
Washington-Nowata		H. E. Denyer, M.D., Bartlesville
Woods	I. F. Stephenson, M.D., Alva	M. F. Monfort, M.D., Alva

THE JOURNAL

of the

OKLAHOMA STATE MEDICAL ASSOCIATION

EDITORIALS

COBBLER STICK TO YOUR LAST

The central office of Blue Cross and Blue Shield states that considerable time and effort are constantly being expended by them in attempting to clear up incidents and situations brought about by the local physician. Specifically, they state that the physician makes interpretations of the policies or obligates the companies out of total line of the written policy. This not only causes unfavorable discussions, but in some instances has resulted in undue hardships to the companies.

May we suggest that before you as a physician commit the Insurance Company to an obligation, you counsel the patient to obtain his insurance advice from a representative of the insurance company.—John F. Burton, M.D.

CHRISTMAS SEALS

Now that we have the tubercle bacillus on the run, is the time to buy Christmas Seals. Never since the first seal was sold has there been such an opportunity to do great good with small means. If you join the millions who buy seals, you will help close the gap in the control measures occasioned by the cut in tuberculosis appropriations voted by the 83rd Congress. The cut of $2,240,000 means the withdrawal of Public Health Service aid in case finding surveys throughout the country.

While increased seal sales cannot fully compensate for this loss, it will help to tide us over a critical period and hold the gains we have made in recent years.

Physicians should do everything within their power to speed the Christmas Seal Sale.

If tuberculosis is ever brought under control, it will be through continued cooperation between the physicians and the public. Physicians everywhere should put their shoulders to the wheel and roll up a big sum for control made possible through medical knowledge.

CIGARETTES AND CARCINOMA A CALAMITOUS COMBINATION

A great change has come about since Lord Fairfax addressed George Washington as follows: "Dear George: I would that you smoked a pipe. It confers great equanimity in times of doubt, and the Indians hold it to be helpful in council." Though the satisfying aroma and the choice flavor of old, represented a blend of all the contributions of chickens, cats and dogs to the "filthy weed" while it rested in the bulk on the old fashioned farm, it never seemed to do any harm. The "early settlers" smoked and chewed with impunity. Would that we knew the source of their immunity. Could it be chicken dung or cat or canine?

The purified, processed product converted into cigarettes seems to be doing something it never did to the Indians. Our aging modern chain smoker is now succumbing to bronchogenic carcinoma at an ever increasing rate. Those who have devoted much time and thought to research in this field are convinced that there is an intimate relationship between long, continued smoking and the rising incidence of carcinoma of the lungs. Alton Ochsner, M.D., in a recent conversation on this subject, ventured to say, "unless we quit smoking or find some way to eliminate the carcinogenic factors in the tobacco that goes into cigarettes, the male population may be decimated within 50 years."

The crafty Indians have been defeated on every hand and crowded into arid reservations. It is possible that in the end they may achieve a bitter revenge through "the weed" that failed them in council.

This from a modern poet suggests that they have not forgotten.

"From my ledge above the flint beds
I hear ghosts chipping arrowheads"

It is not too late for self council. Shall we smoke or shall we not? Here lies the rub. On this count, ill council may lead to

cancer. The evidence is mounting. It may be that your cigarettes are as nails in your coffin. If you shut your eyes there is no pleasure in smoking. If you see clearly, you may find ghosts in the curling exhalations that stir your fantasy. Dreaming over dying embers or even "beaded bubbles winking on the brim" may be just as satisfying with potentialities much less grim.

LONG ON LONGEVITY

According to figures released by the Bureau of Census July, 1951, we had in the United States 12,759,000 persons 65 or over. This represented an increase of more than three and one-half million since April, 1940.

While this high percentage of elderly people have continued to live chiefly because of the best medical care and the highest living standards in the history of the world and while they deserve more and better than they are receiving, their presence in ever increasing numbers poses a serious socio-economic problem.

The cost of giving good care to elderly people in this progressive age has increased enormously and daily it mounts toward higher levels. This is a problem which should have careful attention before it becomes insurmountable.

In the July, 1953, issue of the **Journal**, the plan of Russell I. Garton was discussed and the hope expressed that something constructive might be done before it is too late. Here is a problem with socio-economic and medical aspects commanding the consideration of the best minds in every community, including the cooperation of all forward looking physicians.

"All the world's a stage . . . and one man in his time plays many parts" before he rounds out his "seven ages." Even though he has passed the "lean and slippered" stage and passed into the "last scene of all . . . sans teeth, sans eyes, sans taste, sans everything," he must not be sans sympathy and care.

These elderly people deserve something more than orange juice and coffee — those who have intellectual capacity need spiritual support. But it must be agreed that what Ulysses ordered for his father. Laertes, is equally essential — "warm baths, good food, soft sleep and generous wine." We might add, "with beaded bubbles winking on the brim."

AN IMPORTANT NEW JOURNAL DEPARTMENT

Our readers are urged to give attention to the first appearance of "Notes from the Executive Secretary's Office".

If the significance of this department may be judged by its present contents, it has a promising future.

The Editorial Board has long been impressed with the fact that much of the knowledge exhibited by our astute Executive Secretary and his competent Associate should be made available to the Association membership. Also that many of the innumerable problems continually arising in the Executive Office should be made known to our readers. Very few of our members have any idea of the daily load of the perennial grind confronting the millstones at the Executive Office.

This department may help you to better understand what the Association is doing for the public; what you get for your money and it may astonish you to see how much can be accomplished with so little.

Meet Our Contributors

Richard W. Payne, M.D., Oklahoma City, wrote the article, "Emergency Administration of Cortisone," in this issue. Doctor Payne, whose specialty is internal medicine, was graduated from the University of Oklahoma School of Medicine in 1943. He served as a captain in the army medical corps and after several years in private practice, he is now associated with the department of pharmocology at the University of Oklahoma School of Medicine.

William S. Jacobs, M.D., Tulsa, is the author of "Coronary Artery Disease" in this issue. Doctor Jacobs received his A.B. from the University of Tennessee in 1938 and was graduated from the University of Pennsylvania School of Medicine in 1942 after which he served until 1946 as a major in the army medical corps.

This issue of the *Journal* again carries the Clinical Pathologic Conference and authors are *Howard C. Hopps, M.D.*, and *Patrick S. Nagle, M.D. Doctor Hopps*, who is professor and chairman of the Department of Pathology at the University of Oklahoma School of Medicine, is well known to *Journal* readers as he has contributed many previous articles to this department. He has been certified by the American Board of Pathology and was graduated from the University of Oklahoma School of Medicine in 1937. *Doctor Nagle* has been certified by the American Board of Surgery and is a member of the American College of Surgeons. He was graduated from the University of Oklahoma School of Medicine in 1928. During World War II, Doctor Nagle served 40 months and held the rank of major in the medical corps.

John W. Keys, Ph.D., and *Robert L. Millier, M.S.*, Oklahoma City, are co-authors of the article, "The Oklahoma Conservation of Hearing Programs." Doctor Keys is professor of speech at the University of Oklahoma and director of the Speech and Hearing Clinic at the Crippled Children's Hospital, Oklahoma City. Mr. Millier is traveling consultant in audiology.

Scientific Articles

BLADDER TUMORS*

James C. Sargent
Milwaukee, Wisc.

It is rare indeed that a person comes to learn that he has a tumor of the urinary bladder except through the advent of a spell of gross, total hematuria. Very rarely a pathologic fracture or some other form of metastatic pathology starts a search for a primary tumor that finally ends in the urinary bladder. Similarly a very, very few bladder tumors are found in the course of a general urologic examination or through the routine or periodic cystoscopy of those who, working long and intimately with the aniline dyes, are notoriously prone to develop bladder cancer. By and large, however, it is the startling experience of an episode of gross hematuria—sudden to come, completely without other symptoms and soon to go—that tells the story.

When, after months or years of occasional episodes of hematuria, cancer of the bladder has progressed to the point of deep vesical involvement with extensive sloughing of the tumor mass, other symptoms develop which must be recounted if only as a matter of academic interest. Little of clinical usefulness can be attached to these late symptoms, however, since any diagnosis that awaits their confirmation can hardly be of practical value to the patient. If cancer of the bladder is to be cured, the presence of tumor must be recognized long before these distressing terminal symptoms have developed.

When the cancer has advanced to the point of frank sloughing, heavy infection of the bladder cavity inevitably follows. Hematuria, either gross or microscopic, becomes constant and frequent, painful urination becomes distracting. If massive malignant infiltration surrounds and strangles either of the two ureteral orifices, renal pain and tenderness with symptoms of sepsis develop announcing pyonephrotic destruction of the kidney. And in the internal urethral orifice be caught in the spread of malignant induration, the usual signs of urinary obstruction develop and bilateral pyonephrosis soon adds failing renal functions to the clinical picture. Indeed, it is the urosepsis resulting from renal damage of this sort that ultimately leads to death in most cases of bladder cancer. In rare cases a cancer may involve the bladder dome and attach itself to and invade a loop of intestine, producing intestinal symptoms and leading finally to an enterovesical fistula. When a patient with long-standing hematuria begins voiding gas and fecal matter, one need hardly cystoscope him to know what has occurred. Similarly, when a woman develops urinary incontinence after months or years of hematuria, one hardly need examine her to know she has a cancerous vesicovaginal fistula. And, finally, the symptoms of generalized malignancy are too familiar to need relating.

Time was when it was quite the thing to look upon a few days of hematuria as something in the nature of nosebleed. Some doctors still do, but their ranks are thinning and their days are numbered. Fortunately, through just such meetings as this the word is getting around—both in and out of the profession—that when anyone bleeds from any of the body orifices, both he and his physician had better find the reason why. Coughing blood, vomiting blood, urinating blood, bleeding from the bowel and any unnatural bleeding from the vagina all mean business. And often enough to make careful investigation mandatory, such bleedings mean cancer.

There are two points in connection with hematuria that need emphasis as you look at Figure 1. It has been drawn to portray the significance of total gross hematuria; not miscroscopic hematuria and not terminal urethral bleeding. Were a similar diagram drawn to portray the circumstances under which microscopic red cells are found in the urine, nephritis of one type or another would occupy most of the circle rather than the

*Presented before the Section on Urology at the Annual Meeting of the Oklahoma State Medical Association, April 14, 1953.

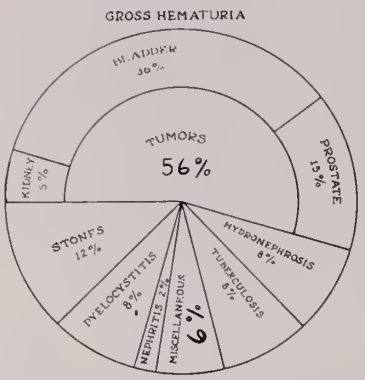


Fig. 1



Fig. 2



Fig. 3

Fig. 1. Indicating the relative frequency with which common urologic diseases are found as the cause of gross total hematuria.

Fig. 2. Schematic drawings representing (a) benign papilloma, (b) malignant papilloma with early bladder wall invasion, and (c) deeply invasive infiltration carcinoma.

Fig. 3. Indicating the varying information gained from different sections of a papillary tumor undergoing maligant degeneration.

puny two per cent indicated here. And if we were to portray the signifiance of terminal bleeding — bleeding from the urethra after the bladder has emptied itself of its normally clear urine—the circle would be occupied almost completely by simple inflammatory congestion of the mucosa of the bladder neck and prostatic urethra. But when a person voids a urine frankly bloody from start to finish, it means that something somewhere within the bladder or above is bleeding actively. Then, as may be seen from the diagram, the chances are better than even that the patient has a tumor, and the chances are almost two to one that his tumor is in the urinary bladder.

Once hematuria has occurred and its warning is heeded, the recognition of a bladder tumor is quite easy and direct. Cystoscopy simply must be done. And I would stress the importance of doing cystoscopy at once—while the patient still is bleeding. There is no particular advantage to immediate cystoscopy if the patient proves to have a bladder tumor because a tumor sitting on the bladder wall and staring one in the face could hardly be missed by the cystoscopist, bleeding or no bleeding. But if there is no tumor within the bladder to explain the hematuria, it is of immeasurable assistance to the cystoscopist to have a flow of blood to guide him to the source of bleeding—a bleeding varicosity in the mucosa overlying an enlarging prostatic lobe or, in the case of a renal lesion, an intermittent spurt of bloody urine from one or the other ureteral orifices will indicate which of the two kidneys is doing the bleeding.

If treatment is to be at all definitive and prognosis anything more than pure speculation, there is much more to the diagnosis ureteral orifices will indicate which of the recognition. Its degree of malignancy must be determined. And the depth of invasion into or through the bladder wall must be determined. It is perfectly obvious from the three sketches in Figure 2, that the matter of malignancy, and especially that of malignant infiltration, must govern in the handling of any bladder tumor. The so-called benign papilloma represented in the first view can be destroyed nicely by simple transurethral electrocoagulation. Destruction of only the protruding part of the second tumor, however, would be obviously inadequate. And in the type of tumor indicated in the third view, anything short of radical surgical removal would be palpably futile.

The question of remote metastasis must, if possible, be determined. And there are other less fundamental but none the less practical matters to be considered. The location of the tumor within the bladder may determine to a large extent its curability. A large infiltrating cancer in the dome of the bladder is often curable simply by excising the top half of the bladder, taking with it a wide margin of normal bladder wall. On the other hand, a relatively small cancer infiltrating deeply into the muscularis at the bladder neck demands the somewhat more dangerous and very mutilating procedure of total cystectomy—prostate, seminal vesicles, bladder and all—not to mention the added procedure of ureterosigmoidostomy or skin ureterostomy to provide for the future egress of urine. And since most bladder tumors occur near one or the other ureteral orifice, it becomes necessary to study the upper urinary tract to determine the degree of

renal damage that has occurred from strangulation of the lower ureter as it passes through the cancerous growth.

Much information concerning the degree of malignancy can be gained by careful cystoscopic study of the gross appearance of a bladder tumor. Practically all low-lying, broad-based tumors are of relatively high malignancy and deeply invasive. Especially if ulceration and encrustation is present or it areas of leukoplakia within the bladder suggest a tumor to have elements of metaplastic squamous epithelium they are certain to be highly malignant.

The papillary tumors vary widely in their malignancy. In general the smaller the tumor, the more delicate its frons and the more narow its pedicle, the less malignant it will be found to be. Aside from these general characteristics there are three other matters to be carefully observed in the cystoscopic study of tumors, each of which gives much information as to their malignancy. Tumors that are multiple, whatever their cellular structure may be, are likely to recur and in a clinical sense are more malignant simply because of their multiplicity. Areas of ulceration and encrustation mark a papillary tumor as being malignant. And any material increase in vascularity with elevation of the mucosa surrounding the pedicle of a papillary tumor always suggests submucous infiltration marking the tumor both malignant and highly invasive.

Even a simple papilloma with delicate frons, a small pedicle, a completely innocent cellular structure and no invasiveness whatever is a potentially malignant tumor. However innocent it may appear, it tends to spread or implant itself elsewhere within the bladder and, once destroyed, it tends to recur. I shall not defend any particular dogma concerning the reason why papillary tumors within the urinary tract so tend to multiply and to recur. The modern concept, I am told, is that this trait represents multiple independent foci of tumor development associated, perhaps, with a carcinogenic factor within urine itself. Having lived for a generation believing that one parent tumor begets others either by direct transplantation or by submucous spread of tumor cells, I confess I find it awkward to switch allegiance to this newer theory. The matter is not of particular clinical importance, however. The important thing is the fact that these tumors do have an amazing habit of being multiple and of recurring, either at their original site or elsewhere, once they have been removed. It is this tendency for papillary tumors to recur that makes repeat cystoscopies so important for several years after destruction—that, together with the possibility that a recurrent tumor might undergo important malignant changes before symptoms appeared to announce its presence.

Destruction of a small benign papilloma ordinarily is a very simple matter. With a bit of fortitude on the patient's part, one often can be coagulated through the cystoscope as a simple office procedure. It were far better, however, that the patient be hospitalized and anesthetized to permit removal by a clean cut with the loop of the resectoscope followed by heavy coagulation of the area of the bladder wall from which the tumor has sprung. There is more finality to such a procedure and, besides, it has the added advantage of furnishing biopsy material to check against the occasional case of real malignancy in a small tumor of disarming appearance.

I am certain our pathologists will bless me for showing Figure 3. Its message of course has to do with the proper collection of material for biopsy of a bladder tumor. Like most schematic drawings it oversimplifies matters somewhat. Yet it is perfectly true that the story the pathologist reads from the cellular structure of a section of bladder tumor can vary considerable depending upon the location from which the section is taken. There are tumors sufficiently malignant to lead to early death, having areas such as "A", which any pathologist would grade very low in the scale of malignancy. And a section taken at "C" by including tissue from the bladder wall itself would add the significant fact that the tumor is highly invasive and the more dangerous.

This same Figure 3 will serve well to illustrate the clinical problem that is presented by a true papillary carcinoma of the urinary bladder. They can vary in size from that of a pea to that of a hen's egg and still fall within the architectural pattern that this sketch portrays. There is no problem in all urology that is so confusing and so challenging as that presented by a tumor of this type. If the tumor lies high in the bladder vault the answer is fairly simple. Subtotal resection of the tumor-bearing area then can be radical and still leave the urinary system intact. Unfortunately, however,

most tumors occur at the bladder base near one of the three important orifices, and anything like adequate surgical treatment becomes a difficult and mutilating affair. As the years pass I find myself growing more bold with this type of tumor. Yet, when invasion is not palpably deep within the bladder wall and when adequate open surgery necessitates sidetracking the urine from one or both kidneys, my inclination still lies on the side of transurethral resection. A substantial number of tumors of this type can be cured by bold resection providing there is minimal invasion of the submucosa. And the immense gratification of having left one with his urinary apparatus functioning normally is too great to be taken lightly. To be at all thorough and effective in the transurethral resection of an infiltrating bladder tumor, one cannot rest with destruction of the intravesical mass and then brushing the base lightly with the coagulating current. Cure of such a cancer necessarily must involve complete resection, both in depth and in breadth, of all of the bladder wall harboring cancer cells. Nearly the entire thickness of the bladder wall must be cut away with the wire loop, and the cutting must be carried well beyond the evident margins of the tumor. That calls for a high degree of courage and dexterity. The risks, however, are not forbidding if one leaves for open surgery those tumors of that part of the bladder dome that is covered by peritoneum. Even deliberate full thickness resection of a sizable area of the fixed bladder wall usually can be accomplished with complete hemostasis, and a week or two of careful postoperative cathether drainage will ordinarily suffice to prevent perivesicular extravasation of urine. In those few cases in which bleeding gets out of bounds or urinary extravasation occurs requiring secondary suprapubic exposure, the procedure still has the advantages of having permitted destruction of the tumor under far better visualization than in the opened bladder and of escaping much of the danger of planting uncooked and viable tumor cells into the fresh cut tissues of the cystotomy wound. Incidentally, neither the proximity of one of the ureteral orifices nor the internal urinary meatus requires particular consideration in resecting a bladder tumor. If they are cut clean with the wire loop and not too heavily coagulated, their lumen will re-establish nicely and without much tendency to stricture.

Before leaving this matter of loop resection and electrocoagulation of papillary tumors, I would venture the suggestion that the procedure be made standard as a preliminary phase of any open surgery that is to be done. Tumor cells will implant and thrive in fresh cut tissue and this is particularly true of cells from papillary tumors of the urinary bladder. There is nothing quite so disheartening as to see this sort of implantation metastasis in the belly wall after having opened a bladder to excise or otherwise destroy a papillary tumor (Fig. 4). The danger of this implantation metastasis is just great enough to make one hesitate managing a papillary tumor of the urinary bladder by open surgery. If a tumor can be adequately destroyed by electro-resection and coagulation, it should be done transurethrally. Even in tumors of the fundus where radical subtotal resection seems so promising, if the tumor is of papillary nature it were far better that it be resected and coagulate transurethrally before proceeding with open surgery. And whenever I do have occasion to open a bladder containing live tumor tissue, I am just old fashioned enough to want to slush out the wound with a can of ether. I know of no reliable figures to prove that it reduces materially the likelihood of this sort of tragic complication but I do recognize the danger and I always have an abiding hope that ether will make some difference in the viability of fragmented tumor cells.

Despite all the worth that lies in the transurethral management of bladder tumors, there still are certain types and degrees of bladder cancer that are completely beyond any such conservative means. A certain small percentage of bladder cancers begin as highly invasive, low-lying and rapidly ulcerating lesions (see Fig. 5). To whittle away and cook such a tumor is but to scratch its surface. With cancerous invasion extending deep into the bladder wall and beyond, nothing in the way of surgical treatment short of complete and clean excision of the entire lesion can hold the slightest promise of cure. If tumor cells have reached the regional lymph nodes they, too, must be removed by block dissection. And if the tumor has extended beyond the regional lymph glands, there can be no hope whatever of cure.

Perhaps it is well to digress at this point

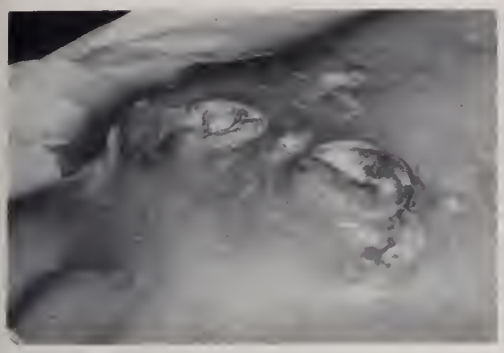


Fig. 4

Fig. 4. Implantation metastasis in wound following subtotal cystectomy for papillary carcinoma of the urinary bladder.

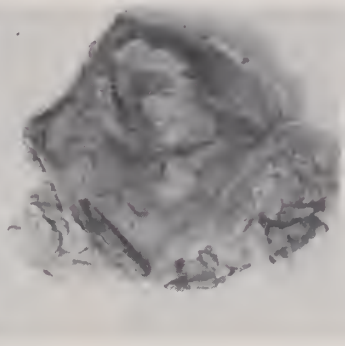


Fig. 5

Fig. 5. Infiltration carcinoma of the bladder dome cured by subtotal cystectomy.

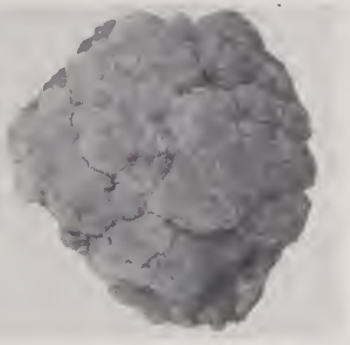


Fig. 6

Fig. 6. Cystectomized bladder inverted to show mass of papillary tumor tissue that completely filled its cavity.

and mention the fact, both interesting and of enormous import, that bladder cancers are comparatively slow to metastasize. Indeed, it is the rule rather than the exception for a pathologist to examine the body of one dead of bladder cancer and not be able to demonstrate metastatic lesions, death having occurred from a combination of uremia and sepsis the result of obstruction from malignant infiltration of the lower ureters or the bladder neck. For cancer thus to cause death without the advent of remote metastasis is a circumstance quite unique in tumor pathology. It is this lag in the remote spread of cancer that is the basis upon which reasonable hope may be held for the cure of even advanced bladder cancer when circumstances permit surgical treatment sufficiently radical to remove all of the local pathology.

In Figure 5 one sees a highly malignant, highly invasive cancer that happened to develop in the bladder dome. Peritoneum overlying some of its outer surface was puckered and thickened in testimony of the complete cancerous penetration of the bladder wall. Following wide excision of the tumor-bearing area in the fundus, this elderly woman hardly had more than the edges of her trigone left to sew into a sort of bladder around the head of a Pezzer catheter. Yet she lived for years, and died with a normal bladder — not alone free from tumor but normal in size and capacity. The curability of advanced bladder cancer is sometimes surprising, and the power of regeneration of the bladder wall is nothing short of amazing.

While the majority of papillary bladder tumors can best be managed by transurethral methods or by subtotal cystectomy, there are certain types in which nothing short of total extirpation of the entire tumor-bearing viscus could be considered at all adequate. This is true of the relatively benign tumors that recur with great persistence or

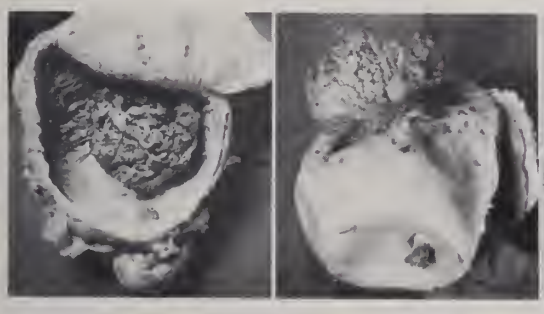


Fig. 7

Fig. 7. First view shows the opened bladder, the entire bladder together with the prostrate and seminal vesicles having been removed in a single mass. Second view shows the bladder everted with the large parent tumor in the vault and a smaller secondary tumor near the internal urethral orifice.

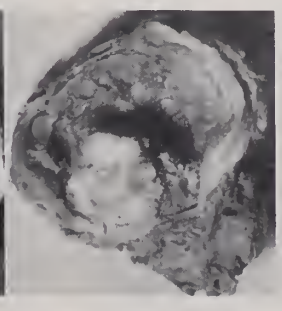


Fig. 8

Fig. 8. Grade III papillary carcinomata involving the entire thickness of the bladder wall.

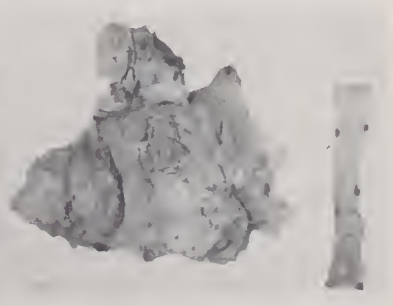


Fig. 9

Fig. 9. Cysto-ureterectomy for implantation papillary carcinomata in ureteral stump and bladder following nephrectomy for renal tumor.

when as in Figure 6, they grow rapidly and are distributed widely over the entire bladder surface. This bladder has been turned inside-out and one can readily appreciate the utter futility of any effort at cure other than that of total cystectomy.

The indication for total cystectomy is equally clear when a malignant papilloma has metastasized within the bladder itself, however tempting less radical procedures might be. In viewing the picture of the inverted bladder in Figure 7, it is evident that the large parent tumor might have been removed with a wide margin of adjacent normal bladder wall and the secondary tumor tissue near the internal urethral meatus destroyed by electrocoagulation, thus leaving the patient with an intact and functioning bladder. Desirable as that might have been, however, it would violate the simple clinical fact that, once a malignant papilloma has occurred at a second site within the bladder, whether through the predilection of some carcinogenic factor or through submucous lymphatic extension or through pure cell implantation, thereafter other tumors can be expected to appear in any bladder mucosa left remaining.

Any tumor on the bladder base that is sufficiently invasive to present palpable induration on rectal examination is certainly beyond the possibility of surgical cure except by total cystectomy. When this finding is to be taken as a guide to proper surgical treatment, however, palpation must be done under the muscular relaxation of a general anesthetic. Not infrequently an invasive tumor near one or the other ureteral orifice, entirely beyond the ordinary reach of a palpating finger, can be caught bimanually under anesthesia and its zone of intramural induration clearly outlined. Once intramural or pericystic invasion is clearly palpable, radical cystectomy is the only surgical procedure that could possibly promise hope of cure. (see Fig 8).

Comparatively rare though it may be, I cannot refrain from making mention of the occasional occurrence of bladder tumor as a secondary lesion metastatic from a parent papillary tumor of the renal pelvis. Two years before, a patient (see Fig. 9) had had a nephrectomy elsewhere for renal tumor. Its exact nature is not known, but with malignant papillomatous lesions in the remaining ureter and others within the bladder, it is a safe assumption that the renal tumor was a papillary carcinoma. In any event the illustration shows the importance of removal of the entire ureter and making careful cystoscopic study for possible bladder transplants whenever nephrectomy is done for a papillary tumor of the renal pelvis.

Until quite recently total cystectomy was too formidable a procedure to be undertaken by most surgeons and then only as a last resort. The procedure was made doubly complicated and difficult by having to divert the urinary stream either to the skin surface or to the lower bowel—the former a most disagreeable inconvenience to the patient and the latter fraught with many disturbing renal complications. Moreover, local recurrence in the stump of the prostatic urethra or body of the prostate and seminal vesicles soon pointed to the added necessity of complete extirpation of these organs together with the bladder specimen. And finally, hemorrhage and shock were formidable deterrents to such radical surgery in patients at all debilitated or well along in years.

Thanks to one of the great lessons of the recent war, however, whole blood has come to be almost routine during heavy surgical procedures of this sort. Nowadays with two or three pints of whole blood given before and during operation a patient leaves the operating table in excellent condition despite a blood loss that in prior years would have been considered prohibitive. Anesthesia has been improved immensely and one or two hours in the operating room no longer is an important factor mitigating against radical operations of this type. What with this greatly widened margin of safety, and especially with the danger of infection from fecal contamination greatly reduced by the modern wonder drugs, it even has come to be a perfectly safe routine to complete the bowel implantation of both ureters simply as a step in the overall procedure of total cystectomy.

As this running recital of the story of bladder tumors nears an end I must take pains to be sure that I have not left impressions concerning types of tumors and their special forms of treatment that oversimplifies the subject or that indicates that the disease, whatever the stage, is easily and commonly cured. There is nothing about the present status of things that warrants any such optimism. Diagnoses are still too often too late. The early benign tumors, while easily destroyed have a pesky habit of

recurring and their disarming silence often leaves them unnoticed until malignant changes have made their management full of difficulties and often ineffective. Even the quite unusual possibilities that lie in radical cystectomy for advanced cancer of the bladder are greatly nullified by the fact that, until some entirely new and vastly improved means of uniting ureter and bowel is found, the long term effects of ureterointestinal anastomosis will include hazards quite as great if not greater than that of the factor of recurring malignancy itself.

Thus it will be seen that the final answer to the successful treatment of bladder cancer has not yet been written. Surely at some future time an all-merciful Providence will put into our hands some new biochemical development or some physical modality that will permit this dread disease to be more simply and certainly controlled. There are new stirrings both in the field of radiation physics and in the field of hormonal chemistry that give great promise, not to mention the unknown and apparently vast possibilities that lie in the field of atomic energy. Until then, however, surgical treatment in one form or the other will continue the greatest refuge for those with bladder tumor. And as in cancer of the breast, the bowel and elsewhere, the surgical treatment of cancer of the bladder will doubtless reach its fullest development only on that day when better diagnosis, improved surgical technique, and dauntless courage combine to make us all quick to recognize, prompt to proceed, and completely bold and devastating in our attack.

THE OKLAHOMA CONSERVATION OF HEARING PROGRAM*

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Conservation of hearing programs are not new. Many states have had such a program for a number of years while others are in the process of starting one. The state of Oklahoma is in the latter category, having begun its program on a very modest scale two years ago. Even now only 40,700 school children have been tested, and the survey has been completed in only ten of the seventy-seven counties in the state. A complete statistical analysis of the results has been made by our clinical audiologist to whom the credit is due for all the figures in this report.

The purpose of this paper will be to present the general plan of organization of the program, the testing procedures, the cost and results of the testing, and other information which may be valuable to those who may be in the planning stages. It must be kept in mind that we are citing our own program purely as an example for purposes of discussion and that is it not our intention to present it as an ideal plan.

It is obvious that there are certain pertinent questions which must be raised and answered before any plan for hearing conservation can be considered. First of all, it is necessary to decide whether there is a need for state wide testing of children in the public schools. Assuming that there is, and that such a program should be instituted, who will be responsible for its organization and in whom will the authority rest for its proper functioning? What will be the attitude of the medical profession and school administrators toward the proposal? What are the county facilities throughout the state and can their help be elicited? Are suffi-

*Much of this material was presented by Doctor Keys at the Rocky Mountain Speech Conference held in Denver in February, 1953.

cient funds available for the purchase of testing equipment? How much and what type of equipment is necessary? Who will assume the responsibility for following up medically and educationally those children found to have hearing losses? Does the state have an appropriation for special education? Can trained teachers be found who can combat remedial classes for the hearing handicapped? The answer to these other questions must be weighed carefully and conscientiously before serious planning is ever begun.

In setting up a conservation program of this kind, certain definite and well defined purposes must kept in mind. They are:

1. To secure the aid and support of all agencies, local and state, who can in any way contribute to the success of the program and to organize and intergate their services to function effectively in its execution.
2. To develop through all possible channels of communication an awareness on the part of the parents, teachers, and school administrators the importance of good hearing, and its preservation. Conversely, these groups must also be made aware of the possible implications for those who lose their hearing.
3. To find and refer for medical treatment those children found to have hearing losses.
4. To provide special educational opportunities by trained personnel for those children who need it.
5. To set up an adequate and consistent means of follow-up to check on both medical and educational progress of children found to have hearing losses.
6. To encourage communities and counties to set up their own programs of hearing testing and assume the responsibility implied for its operation.

THE ORGANIZATION OF THE PROGRAM

Hearing conservation in the state of Oklahoma is a cooperative venture in preventive medicine by the University of Oklahoma Speech and Hearing Clinic, the Maternal and Child Health Division of the State Department of Education. The clinical audiologist is a member of the clinic staff, but receives his salary through the Commission for Crippled Children. The Department of Health plans the testing itinerary, furnishes all of the testing equipment, and makes all the contacts with the county health units. The State Department of Education makes the necessary introduction of this program to the public schools. This arrangement has proved to be very effective and it has the added advantage of bringing to bear the efforts of several groups in a concerted and cooperative endeavor on a state wide problem.

CRITERIA

The criteria adopted for medical referral were those generally recommended for survey testing—a loss of 20 decibels in two frequencies or 30 decibels in one.This standard seems to be a reasonable one for two reasons: the testing conditions are usually not ideal since noise presents a real problem in audiometric testing in the public schools; and requirements which are too rigid present a danger of over-referral which elicits criticism from doctors and parents alike. The test frequencies employed in group screening were 500, 4000, and 6000 cycles. Individual screening tests employed test frequencies from 250 cycles through 6000 cycles.

The selection of the counties for hearing testing came as a result of the expressed desire of doctors, Health Departments, P-TA groups or school administrators within each county. The adequacy of follow-up facilities already existent within the county such as a health unit or other organized groups willing to assume the necessary responsibilities, was also a consideration. One county was tested at a time. All of the children from the first through the sixth grade received hearing tests. The group audiometer was employed in evaluating the hearing of all children in grades three, four, five and six while the youngsters in the first two grades were given individual audiometric examinations. In some schools, the seventh and eighth grades were included in the survey.

MEDICAL ORIENTATION

When a county was selected for testing, arrangements were made through the county health office for an orientation program at the regularly scheduled meeting of the medical society. Since the key to successful medical follow-up is the local or family physician, the organization and general outline of the program was presented for his approval. The group audiometer was explained and demonstrated and the audiogram discussed at some length. The part which the doctors were invited to play in the total program was revised and emphasized. Thus, every effort was made to en-

courage the doctors to participate wholeheartedly in the program. This they have done almost without exception.

EDUCATION ORIENTATION AND PROCEDURES

The second phase of the organizational part of the program consisted of a workshop held within the county which was attended by representatives of the various school systems. School personnel and health department nurses were given an intensive orientation course in hearing conservation at the workshop as well as instruction in the use of the audiometers and multiple phones for screening purposes. School personnel were used to administer all of the group tests in the school system. Children failing the first test (about 14 per cent) were given a second screening test at a later date, and those failing the second test were referred to the traveling audiologist for a final individual audiometric examition. Children demonstrating a loss of hearing acuity greater than that allowed by the criteria were referred for medical or otological attention.

METHOD OF REFERRAL

The actual referral of children to the doctor was made by form letters from the local health department or sponsoring group to the parents of the child, the participating school, and the family physician through the parents' letter. The responsibility for obtaining medical attention was placed on the parents who were requested to take their child to their local or family physician for an examination. Children who were found to be in need of special attention were appropriately referred by the family physician to an otologist. Crippled Children's Services were selectively used so that no child need be denied medical attention because of financial difficulty. In counties where health departments were utilized, the nurses began a program of follow-up one month after the detection of the children. In some cases, school authorities assisted in checking on the referred children and seeing the parents. Where further hearing tests and evaluations were necessary, children were referred to the University of Oklahoma Speech and Hearing Clinic.

Regrettably, referrals for special educational training were not possible in most instances since the majority of schools do not yet have specialists available for this purpose. Admittedly this is a severe deficiency, but fortunately, the state legislature has recently reinstated a special education bill which will provide funds for remedying this situation eventually.

PARENT EDUCATION

The third phase of the program at the organizational level was a sincere effort to inform the parents and general public of the general purpose of and need for hearing conservation. This part of the program cannot be overemphasized. Results showed that there was a direct relationship between the intensity of the educational program in the community and the number of referred children who actually reported to the physician's office. During the detection program within a county, the communities were bombarded with newspaper accounts of the programs, radio talks, and parent-teacher programs on the conservation of hearing. Educational films were shown, audiometer tests were demonstrated, and talks on the prevention of deafness and protection of the ears were made. Printed pamphlets announcing the testing program and including the "danger signals" of ear disorders were used with success. Every effort was made to present hearing conservation and aural hygiene to all communities.

RESULTS

A general summary of results is listed below:

1. Of the 40,700 children tested in 10 counties of the state, slightly less than 2.7 per cent were found to have hearing impairments.
2. Of this percentage, 64 per cent were boys and 36 per cent were girls.
3. Twenty-five per cent of these children had records of one or more grade failures. Particular attention should be called to this figure since it is considerably higher than would be expected from a normal school population. It could not, of course, be assumed that all of these failures were directly attributable to a hearing loss, but it is safe to say that a good many were. If one were to estimate that only 50 per cent failed because of a deficiency in hearing, the cost to the state and community in expense for the grade repetitions (figuring $200 per pupil per year which is generally accepted as a reasonable per capita cost for educating a child in the public schools), would be sufficient to carry on a hearing conservation program in those counties for at least three years.

4. Thirty-five percent of the referred groups reported frequent colds and 23 per cent reported one or more instances of running ears within the past year. Although there is admittedly a degree of error in the subjective reports given by children, sufficient supporting material was obtained from other sources to verify the belief that these figures are not greatly in error.
5. Twenty-five per cent of these children had seen a doctor about their ears but only 19 per cent were aware that they had a hearing loss.
6. Teacher referrals for hearing impairment are completely inadequate. In a controlled study of the effectiveness of such referrals in one school system, it was found that only 14 per cent of the children actually having a hearing loss were detected by the teacher.
7. The grade distribution of the hearing impaired children shows that the greatest incidence of hearing loss is found in the fifth grade. The number of children in the sixth grade showing a hearing deficiency drops sharply. It is perhaps a reasonable assumption that children with serious hearing losses do not usually get beyond the fifth grade in their academic works. Otherwise, it is difficult to account for the great discrepancy between the two grades.
8. The incidence of hearing loss in negro children is markedly less than in white children. Of 3,000 negro children examined only one-half of 1 per cent evidenced a hearing loss.
9. The number of referred children who eventually sought medical advice varied widely from county to county. The range actually extended from 7 per cent in one of the counties tested to 75 per cent in another with the average approximately 40 per cent. This wide variation was caused by several factors, some of which are difficult to change. In those counties where the socio-economic level was particularly low, many parents were more or less indifferent to such a small complaint as an ear ache. Such an anomaly had been a common complaint with the child's father in his youth, and the fafather's father before that. It was simply one of those penalties one paid as a natural consequence of growing up. Part of the difference in the percentages may be accounted for by the amount of educational training that was possible in the community before and during the actual testing and another part was due to the enthusiasm and conscientiousness (or lack of them) of the health center or organization pushing the program. Certainly, however, a means must be found for increasing the rate of referral, if this program is to be meaningful.

TABLE 1
ANALYSIS OF AUDIOGRAMS

Classification	No.	Per Cent of Ref. Child
Hearing Impaired Children showing a loss of more than 30 db. ave. (500-2000) but less than 40 db. ave. (500-2000) in one ear only	119	11.0%
Hearing Impaired Children showing a loss of more than 30 db. Ave. (500-2000) in one ear only	81	7.5%
Hearing Impaired Children showing a loss of more than 30 db. Ave. (500-2000) but less than 40 db. ave. in two ears	70	6.5%
Hearing Impaired Children showing a loss of more than 40 db. ave. (500-2000) in two ears	30	2.8%
Hearing Impaired Children showing a loss only at 4096 cycles greater than 30 db. in one ear only	72	6.7%
Hearing Impaired Children showing a loss only at 4096 cycles greater than 30 db. in both ears	100	9.1%
Hearing Impaired Children showing a high tone drop with loss at 4000-6000 cycles only in one ear	50	4.6%
Hearing Impaired Children showing a high tone drop with loss at 400-6000 cycles only in both ears	100	10.0%
Hearing Impaired Children with audio grams less than 30 db. ave. (500-2000) in either ear or both and with audiogram character other than the 4096 cycles "dip" or "high tone drop at 4000-6000 cycles"	449	41.8%
	1079	100.0%

10. Table number 1 presents an interesting analysis of the audiograms on the children referred. The amount and average decibel loss are classified with the number of children who fell in each category.

One of the interesting points worthy of special attention which emerges from these data is the large number of children about 16 per cent, who show a "4096 dip or tonal island" on their audiogram. Ordinarily a precipitous drop at this particular frequency alone has been attributed to acoustic trauma or extreme exposure to loud noises over a period of time. The fact that most of these children could not possibly have been ex-

posed to such an environment should point up the need for the study of other considerations as a cause for this type of loss.

It also becomes apparent in the study of these figures that many of these children can benefit greatly from proper and advantageous seating in the class room. Children with unilateral loss, although not greatly handicapped in terms of hearing acuity under ideal conditions, may suffer if seated in such a way that the "good ear" cannot be used to advantage.

A certain percentage of these youngsters will receive benefit from a hearing aid and special training. Judgment relative to such recommendations is, of course, a matter which must be decided in terms of each individual child. Generalizations from the table would be hazardous regarding those cases.

COST OF THE PROGRAM

The expense involved in the actual hearing testing of children in the public schools is not great. In fact, it is surprisingly small. Including the salary of the clinical audiologist, his traveling expenses and depreciation on all test equipment, the cost to test each child was approximately 24 cents, about the price of a package of cigarettes at current prices. This does not seem to be an exorbitant amount to pay as an insurance for the conservation of our youngsters' hearing.

GENERAL REMARKS AND RECOMMENDATIONS

There are certain implications which emerge out of the two years experience in this program. Some of these have previously been inferred in the course of this paper. We should like to list them briefly.

1. A hearing survey becomes important in proportion to the number of referred children who actually will report to their doctor and carry out medical recommendations and treatment to completion. It has further significance if there are special educational facilities available for aiding those children needing special training.
2. These things become possible in turn only through enlightened and interested people in the community. It is therefore, our contention that as the program proceeds and the number of trained personnel becomes increasingly available for public school or county health positions, the responsibility of the program should be more and more turned over to the communities for its execution. At the state level, personnel may be employed to serve in an advisory capacity and to implement the county programs in those ways which seemed advisable. This may never be completely possible but education and public enlightenment are of such vital importance to the success of the program that an overwhelming local interest on the part of educators, doctors and parents seems to be the best possible means of achieving the desired results.
3. It is probably unnecessary to make a complete hearing survey of the entire elementary school population every year although that would be ideal. Certainly routine check-ups at six month intervals on the youngsters who were found to have hearing losses, and all new students entering school should be tested. Such a survey conducted every three years is perhaps sufficient.
4. If a successful plan could be devised for testing the pre-school children, particularly the five year old groups, the incidence, or at least the severity of the hearing loss in the public schools could be greatly reduced.
5. It is our feeling that a hearing conservation program, carefully planned and conscientiously carried out, is a valuable asset to the health and welfare of our children.

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CORONARY ARTERY DISEASE*

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Dr. James Conant has stated that "science advances not by accumulation of new facts but by the continuous development of new and fruitful concepts".[1] This would appear to reflect logical thinking, and therefore, I should like to review briefly the subject of coronary artery disease from two viewpoints. First, I want to consider the subject from the aspect of certain factual knowledge which experience has confirmed, and second, I should like to venture into the realm of some new aspects which promise to dispel much of the attitude of hopelessness which now clouds this disease.

As of today, it is reasonable to predict that unless something specific develops in the interim, one out of every two persons in this audience will succumb to coronary disease.[2] Undeniably this is the most prevalent of all heart afflictions, and its frequency commands our respect.

Time prevents a detailed analysis of the many complexities involved in the phenomena of coronary artery disease. Therefore, I shall select for comment a few factors in this malady which are not infrequently misinterpreted, and which are essential nevertheless for an intelligent understanding of the disease.

The basic alteration in coronary heart disease is an impairment of blood supply to the myocardium as a result of atherosclerosis of the coronary arteries.[3] This is the most prevalent finding of all coronary lesions and is present in 90 per cent of all cases.[4] Let it not be forgotten, however, that the direct etiological factors which precipitate coronary insufficiency are legion. In general, they include three main groups: a) factors which increase cardiac work, b) factors which diminish coronary flow, and c) factors which impair oxygenation of blood.[5] A combination of these three is probably most common of all. Those factors which may increase the work of the heart include severe exertion, emotional stress, eating, sexual intercourse, extremes of temperature, straining at stool, tachycardia, hypertensive and hyperthyroid crises, certain drugs, and overindulgence in food, tobacco, and alcohol. Coronary blood flow may be diminished by shock, hemorrhage, and valvular heart disease, especially aortic stenosis and insufficiency. Other factors which may diminish blood flow through the coronary arteries may include acute heart failure, spinal anesthesia, severe orthostatic hypotension, reflex vasoconstriction from pulmonary embolism, and certain acute abdominal conditions. Factors which may impair oxygenation of blood are anesthesia, high altitude, asphyxia, severe anemia, carbon monoxide poisoning, severe asthmatic seizures and pulmonary insufficiency.

With this brief statement of the general problem, I should like to call your attention to a few facts relating to symptoms, diagnosis, and sequelae in patients who manifest arteriosclerotic changes in their coronary arteries.

SYMPTOMS

The symptomatology of this disease encompasses a wide spectra of complaints—a fact frequently overlooked. Necropsy records reveal that almost 100 per cent of men and women over the age of 70 are afflicted with this disease.[6] Yet we see an occasional patient in their seventh decade with no symptoms attributable to their cardiac pathology. This is a small, but interesting group of patients who are devoid of any clinically significant taint of vascular vulnerability. In another group congestive heart failure may predominate the symptomatology and in fact cardiac failure may produce the initial symptoms of the progressive phenomena of coronary artery disease. It is well to recall that an acute myocardial infarction may account for sudden and unexplained congestive heart failure. Pain may be absent in these individuals.

In another group gastrointestinal symptoms may result for disease of the coronary arteries. One important and rather common symptom is upper abdominal discomfort due to portal congestion.[7] All too often this is erroneously attributed to indigestion, con-

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stipation or gall bladder disease. In my experience this has been one of the most frequently misinterpreted aspects of coronary artery disease; namely, the realization that certain gastrointestinal complaints may have a cardiac basis.

In another group of patients cough may produce the first clinical evidence of this disease.[8] Predominately the cough may occur at night and may herald acute pulmonary congestion. Complete relief from an annoying cough may follow adequate response to one of the mercurial diuretics.

Those patients whose cardiac disease is manifested by the symptoms of acute coronary insufficiency or angina are more easily recognized. The typical pain is depicted as a substernal constricting oppression precipitated by exertion or emotional upset, and is relieved in most instances by rest and/or nitroglycerine. The pain may or may not radiate, and occasionally the only discomfort may be located in the jaw, neck, shoulders or arms. I wonder how many times teeth have been extracted for pain which was actually on the basis of coronary insufficiency?

Significantly a patient either has or does not have angina. The term "mild" angina is admissable only as related to symptoms, never as descriptive of the suspected degree of underlying coronary arteriosclerosis.[9] Males are more frequently afflicted than females by a three or four to one ratio.[10] Dock has attributed this to a thicker intima present at birth in the coronary arteries of the normal male as compared to the normal female.[11] It is generally agreed that angina is increasing in prevalence both relatively and absolutely. Today we see more young males with coronary artery disease than were seen a few decades ago.

What is the significance of the development of angina? What are the facts which we are forced to accept concerning angina? Briefly expressed, I think we must accept: 1) the prognosis is uncertain, 2) sudden and unexpected death characterizes the disease, 3) the average length of life after the first symptoms is from five to seven years,[12] 4) 50 per cent die suddenly, predominantly as a result of a massive myocardial infarction.[12] This then entertains the last category of symptoms resulting from coronary disease; namely, the symptoms attributable to coronary thrombosis with myocardial infarction.

It may be surprising that it was not until 1912 that Dr. James Herrick presented the first clear clinical description of coronary thrombosis.[13] The onset may be sudden and unheralded or the insult may follow a history of angina. Frequently the clinical picture may be dramatic. Often the pain is excruciating and characteristicly it is substernal and may radiate throughout the entire chest. There may be associated profuse perspiration and accompanying shock. Rest and nitroglycerine in general fail to relieve the pain, and the clinical picture may indicate an emergency. Ninety-five per cent of all coronary fatalities appear without precipitating cause.[3] The catastrophy may occur during bed rest or sleep. All too frequently a diagnosis of acute indigestion is entertained.

In evaluating cardiacs, I have found helpful the fact that often the patient who has a "coronary" in the past retains almost a photographic impression of the pain and his environment at the time of the attack. Pain not on the basis of a myocordial infarction is more prone to be described with less vivid detail and often the history is clouded by indecisiveness. This was an observation made a number of years ago by Dr. William Stroud, and I have found it helpful.

DIAGNOSIS

I shall refer only to coronary disease manifest a) by angina, and b) by coronary occlusion with myocardial infarction. Earlier it was stated that a patient either has or does not have angina. The most important factor in the diagnosis is the history. In evaluating a patient suspected of having angina were I limited to but one source of information—history, physical examination or laboratory data, I should always choose the history. Twenty-five per cent to 40 per cent of patients with coronary artery disease show nothing abnormal on physical examination and in the resting electrocardigram.[5]

Pain, the sole reliable symptom of angina, is by most investigators considered a manifestation of anoxemia of the myocardium, no matter how brought about.[9] In the vast majority of cases angina can be diagnosed as adequately in the rural areas as in the larger medical centers. In emphasizing the importance of the history, please do not misunderstand, I do not belittle the value of electrocardigram for it is often of tremendous aid, and one should fully utilize the helpful information which it may afford.

In the diagnosis of coronary occlusion

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with myocardial infarction, the electrocardiogram, however, may be of indispensable aid. Where there is death of muscles as occurs in acute myocardial infarction, it is usually possible to precisely localize the necrotic area by electrocardiographic means.

Other findings which result from necrosis of myocardial tissue are fever, leucocytosis, and an increase in the erythrocyte sedimentation rate.

It is well known that there are certain conditions in which the incident of coronary artery disease is significantly increased as compared to the disease in the absence of these ailments. Patients are more prone to develop arteriosclerosis and at a relatively early age if they display the manifestations of hypertension, diabetes, and those conditions accompanied by a high serum cholesterol, i.e., familial hypercholesteramia, myxedema, nephosis, etc.

SEQUELAE

The complications following acute myocardial infarction are more generally appreciated than certain of the sequelae. This aspect of the problem is singularly important in industrial medicine as it involves the advisability of returning to work the employee who has experienced a myocardial infarction.

Infarction denotes actual necrosis of heart muscle and unfortunately an appreciable per cent of patients die as a result of this insult. In those who survive, the necrotic heart muscle is replaced over a period of time by scar tissue which means a weakened heart musculature. This aspect of the problem has been beautifully demonstrated in the human heart and experimentally in the pig heart by Blumgart, Schlesinger, Zoll and their group in Boston.[14] Several factors appear to influence the development of an adequate collateral circulation and thus in turn adequate fibrosis and scarring. A very vital factor appears to be a sufficient period of rest at the time of onset of either the first severe angina or coronary occlusion.

Some of the patients who survive will continue to experience subjective evidence of coronary artery disease as manifest by anginal pain. In these individuals restriction of activity becomes self imposed as a result of their distressing chest discomfort. In another group there will be absolutely no subjective evidence of coronary artery disease. Not too infrequently after several months of rest these individuals will inform their physician that they have never felt better in their life, and no doubt they speak perfect truth. Then there is the occasional patient who experiences a small infarction and after healing, it is necessary to minutely scrutinize the electrocardiogram to find a relic of the past damage. Suppose these patients to whom we refer were performing heavy work prior to their cardiac insult. One patient may have been an oil field roustabout, an active and strenuous job; another patient may have been a packer in a factory which necessitates lifting heavy boxes. Should these men return to their former arduous tasks after months of rest following a myocardial infarction because they are free of pain on exertion and possibly demonstrate very little residual damage as detected by the electrocardiogram? I feel the answer is no, because there remains the same underlying basic pathology, namely coronary artery disease, which produced the initial symptoms and clinical picture.

It is well to remember that in more than 75 per cent of patients who have recovered from an acute coronary occlusion, abnormalities in contraction of the left ventricle will be seen by fluoroscopy or roentgenkymography.[15,16] Paradoxic pulsation with systolic expansion will be observed in nearly half the patients. The individual may feel well and be without complaint, but he still has a weakened, damaged heart and his probability of sustaining another infarction is greater than the individual who has never experienced such a traumatic insult. Intelligent management of these patients entails a program tempered by moderation in all activities. It is important to reduce activity to the point that pain will be greatly lessened or if possible completely avoided and the patient should remain free from fatigue.

This then is the rather distressing picture of coronary artery disease. In the remaining time I should like to review some of the studies that have stimulated the imagination of many engaged in the field of experimental cardiovascular research.

Having progressed through an era rewarded with the conquest of infectious disease, thought and investigation are now directed toward new concepts in the etiology and pathogenesis of the so called degenerative diseases. With increased survival time, indeed the heart affords a compelling challenge for remedy and prophylaxis.

Previously it was mentioned that coronary blood flow primarily is impeded by arteriosclerotic manifestations. Sclerotic changes in the vascular tree follow one of four patterns,

either 1) atrophy of the media and replacement by collagen, 2) calcification of the media, 3) regenerative intimal thickening, or 4) intimal changes which produce atherosclerosis as found in coronary artery disease.[17] It is only the first of this group, atrophy of the media with replacement by collagen, that can be truly regarded as a simple involutional or aging change. Unfortunately the acceptance of atherosclerosis as a natural process of deterioration and decay was for many years responsible for retarding investigation in the field of vascular disease. Not until the 1930's and 1940's did it become evident that atherosclerosis represents an acquired abnormality.[18]

What is the present status of our knowledge concerning artherosclerosis? A few of the more pertinent new concepts show encouraging promise of completely altering our present views concerning coronary artery disease.

It is now believed that lipid metabolism and atherosclerosis are unequivocally closely allied. Fundamentally, the basic and destructive feature of atherosclerosis is the presence of stainable lipid within the lesion.[19] The earliest detectable lesions are small collections of lipids either free or in foamy macrophages and are located just beneath the endothelium. At this stage these small intimal cushions project slightly if at all into the lumen and thus there is no true hinderance to the flow of blood. The endothelium overlying the involved intima is characteristically structurally intact. With the passage of time there is an increase in number and size of the lesions which often coalesce to form large lipid-rich intimal plaques. Now begins encroachment on the lumen of the vessel. As the lesions expand, the foam cells at the depth of penetration in the intima undergo necrosis with resulting discharge of lipids and cellular debris. The central area then becomes converted into a soft mass—the atheroma. Secondary changes begin to occur. There is thickening of the overlying endothelium, disruption of the elastica, fibrosis, hylanization, calcification, etc. There is further narrowing of the lumen of the vessel as a result of continued enlargement of the lesions. If the blood flow, particularly in the coronary arteries is stopped suddenly by thrombosis or by hemorrhage into an atheromatous area, there ensues the well known dramatic clinical picture described earlier. Note that these latter events are but complications in the evolution of atherosclerosis.[20]

It is remarkable that man is the only mammal in which atherosclerosis occurs to any significant degree. Herbert Fox reviewed 10,000 post mortem studies from the Philadelphia zoo, and it was confirmed from this data that in various mammals clinically significant atherosclerosis is practically nonexistent.[21]

Since man is the chief target for this serious and fatal disease, one might ask whether this is a relatively new malady found mostly in our modern society. The answer may be found in an intriguing chapter in medical history. About 40 or 45 years ago archeologists were excavating in the valley of the Nile River. Hundreds of mummies were unearthed which dated back to some 1500 years before Christ. Many of these mummies were in such excellent state of preservation that histological sections were prepared from various parts of the vascular tree and studied.[22] There appeared in 1908 in Proceedings of the Royal Society of Medicine a paper with a most unusual title—"A Report upon the Pathological Condition of the Aorta of King Mernephtah".[23] King Mernephtah reportedly died in the year 1215 B. C. These fascinating studies made it plain that atherosclerosis was a very common disease 3000 years ago.

The factors of race, age, and sex as they influence man's susceptibility to coronary artery disease can be but mentioned.

Among the Orientals, especially the Chinese and Okinawans, atherosclerosis is said to be mild and infrequent.[24, 25] best to accept such data with reservation since vital statistics in these areas are questionable, and also life expectancy is much shorter among these people.

The role played by age in the development of atherosclerosis has been much debated. Present day concepts would no longer necessarily consider the process the result of "the wear and tear of life", but coronary artery disease does become manifest with the passing of time as the disease tends to be slowly progressive.

With regard to the role of sex, suffice it is to say that when compared with the male, the female of the species leads a charmed life with respect to atherosclerosis. Only when they suffer from diabetes or hypertension do females manifest a degree of coronary disease comparable to that of the male.[18]

In the remaining moments I should like to summarize a few of the current concepts regarding lipids as related to atherosclero-

sis. In this domain may well lie the solution of problems which will in time afford a longer, more enjoyable and pleasant life for many. It has been convincingly demonstrated[25] that the atherosclerotic lesions, described earlier, are abundant in cholesterol and cholesterol esters. Other lipids most frequently found are phospholipids and neutral fats. It has been postulated that in the early plaque, lipids are derived from plasma. Recently this theory gained support by giving radioactive cholesterol to animals and then identifying the tagged material directly within the atheromatous foci.[27] In the human most individuals supposedly developing sclerotic vascular changes have been found to have serum cholesterol levels falling within an acceptably normal range. Gould[28] has suggested that our so called normal value for cholesterol may represent a state of chronic hypercholesterolemia.

The vast amount of investigation in this field has not been devoid of certain suggested clinical applications. Dr. John Gofman[29] and his group utilizing a high speed ultracentrifuge have found that the major lipids in serum are transported in the form of giant lipid-protein complexes. These complexes have been identified and quantitated by their specific flotation properties. The patterns of these molecules appear to vary significantly from person to person. However, they are remarkably constant for the same individual over prolonged periods. It would appear that the pattern is subject to modification by diet, disease, and certain drugs. The presence of certain abnormal molocules appear to bear a strong relationship to the development of atherosclerosis in the human subject. Excessive concentrations of these molocules are found in the sera of patients who have experienced a myocardial infarction. Available data would indicate that the concentration of a specific type of molecule is a much more accurate index of existing atheroscelerosis or of prognosticating atherosclerosis than is simply the level of the blood cholesterol.

The question of diet as related to this general problem is confusing. Opinion is sharply divided on the importance of diet in the development and control of atherosclerosis. For those who support the low cholesterol dietary approach in the therapy of coronary artery disease, it is well to point out that cholesterol may be synthesized in the body from acetate which is available from the metabolism of fat, carbohydrate, and protein.[30] It would appear that additional clinical and experimental data are required before the role of diet in this disease can be accurately assessed.

I hope that this sketchy and incomplete survey of the advancements during the past few years in the important field of atherosclerosis has suggested that the attitude of hopelessness concerning disease of the coronary arteries is now beginning to progress toward a feeling of calculated optimism. In considering this affliction we are prone to think in terms of a severely crippling, unpredictable, frequently fatal disease. This is understandable for we must respect the facts as demonstrated. Fortunately however, progress is being made. Thus can we not agree with Doctor Conant that indeed the advancement of science is after all by the continued development of new and fruitful concepts.

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EMERGENCY ADMINISTRATION OF CORTISONE

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The enormous medical interest surrounding the introduction of high dosage cortisone[1] has dwindled to an overcritical and somewhat embarrassed attitude such as often follows an overenthusiastic reception.

It is felt that sufficient evidence has accumulated to warrant revaluation of the drug in terms of what it can do; rather than what it was hoped that it would do. Thus stripped of its "miracle" bunting, cortisone remains a valuable therapeutic agent without the full use of which the medical practitioner is seriously handicapping himself. An analogy between cortisone and habituating analgesics can be drawn in which proper use is of remarkable therapeutic benefit, yet overenthusiastic administration will lead to the dismal situation of unpleasant side effects, increasing tolerance to the drug and desire of the patient for continued administration beyond the therapeutic indication.

THERAPEUTIC INDICATIONS: At the present time one must content himself with the immediate, though frequently temporary, advantages that may be gained in overwhelming disease states through the use of cortisone. Most of the diseases immediately amenable to cortisone therapy have self limiting or variable courses which may include alarmingly acute episodes. It is with the blinding, crippling, deforming, debilitating, severely painful and even lethal early inflammatory phases of these diseases that cortisone performs its greatest service.

The collagen diseases present problems of utmost therapeutic urgency. Disseminated lupus erythematosus frequently develops into an acute fulminating state which can be arrested only with cortisone. It is in the treatment of this disease that the most generous use of cortisone may be found necessary. The efficacy of this agent has been established beyond doubt in preventing the considerable permanent changes occurring during acute episodes of rheumatoid arthritis. We are becoming increasingly aware of the increased mortality associated with rheumatoid arthritis and have hopes for its modification with cortisone therapy. Dermatomyositis in its acute stages with dangerous edema of paralaryngeal structures and paralysis of the respiratory muscles is usually immediately amenable to this form of therapy. The acute carditis accompanying rheumatic fever usually improves under cortisone therapy with subsidence of pericarditis and prevention of valvular scar tissue formation—a response that is often life saving and preventive, at least to some extent, of permanent cardiac lesions.[6]

Anaphylactic shock, angioneurotic edema, allergic purpuras, serum sickness, agranulocytosis, erythema nodosum and other precipitous failures of protective antigen-antibody mechanisms can usually be held in check for the duration of their characteristically short self limiting courses with this drug.

Control of bronchial asthma can usually be accomplished with a large variety of drugs and preventive measures. Yet there is the occasional case that becomes refractory to these agents. Such patients may be helped through a particularly trying period with a short course of effective levels of cortisone—indeed often restoring sensitivity to the other therapeutic measures.

Malignant pemphigus, exfoliative dermatitis, severe atopic dermatitis and similar severe generalized disorders of the skin are usually rendered at least temporarily tolerable with this drug. The pain and scar tissue promoting effects of certain inflammatory eye conditions are frequently decreased with suitable cortisone therapy. New lesions of sarcoidosis and other granulomatous diseases melt away rapidly under the effect of this agent. Temporary respite from the rapid decline of acute lymphatic leukemia in children can often be accomplished and the hemogram of acquired hemolytic anemia, idiopathic thrombocytopenic purpura and occasionally aplastic anemia may show a more desirable trend. The virilization of the adrenogenital syndrome (due to adrenal hyperplasia can be considerably allayed with relatively small doses of cortisone. Addison's disease, particularly under stress, presents the single situation in which the use of cortisone may be considered as a long term therapeutic regime: certainly no one will argue against its use in this condition.

A multitude of other uses of the drug may be found upon even casually scanning the literature on cortisone. These include such conditions as relief of apprehension in terminal malignancies, snake bite, burns, ulcerative colitis, regional ileitis, hay fever,

poison ivy dermatitis, essential dysmenorrhea, hepatic coma, thromboangeitis obliterans, nephrotic syndrome, acute attacks of gout, alcoholism, multiple myeloma, idiopathic hypoglycemia, Hodgkin's disease and many others. It would seem that a short trial of cortisone might be warranted in practically any condition of sufficient severity in which all other therapeutic measures have failed and in which there is no obvious contraindication. Such conditions as malignant hypertension. Cushing's syndrome, active pulmonary tuberculosis, acute infections, active peptic ulcer and congestive heart failure usually render the drug intolerable.

METHODS OF ADMINISTRATION: Oral administration of cortisone acetate is clearly the dosage form of election. In addition to the obvious advantages of oral over parenteral administration cortisone by the former route is usually rapid in onset of action, of comparatively short duration and suffers little or no loss of potency. Thus after sufficient oral dose an effect may occasionally be seen in as little as 30 minutes and effective levels are reached characteristically by at least four hours. This is as rapid as the effect of intravenous injection of suitable preparations of cortisone.[2] Effectiveness lasts six hours, then declines rapidly.

Hydrocortisone, as the free alcohol, given orally holds certain theoretical advantages over cortisone acetate. It is more effective on a weight basis and probably represents the eventual chemical state by which cortisone exerts its peripheral effect. At the present time, however, hydrocortisone does not appear to be superior in therapeutic index and is somewhat more expensive.

Corticotropin (ACTH) does not appear to hold any particular advantage over cortisone and has the disadvantage that it must be given parenterally. The occasional reports of increased effectiveness of corticotropin are probably based on disinclination to push cortisone to a comparable therapeutic level. Occasional use may be necessary, however, in those situations in which rapid effect is desired and medication by the oral route is not feasible.

Local application of cortisone acetate, preferably in an ointment base, in inflammatory states of accessible portions of the eye provides convenient, economical and effective therapy for these conditions. Local inunction of the more soluble hydrocortisone in certain localized skin conditions appears to be an inferior method of administration in its present dosage form.[8] Intraarticular and intrabursal injection of the poorly soluble hydrocortisone acetate into isolated inflammed areas is of particular value in acute traumatic inflammatory states, with prolongation of local effect for periods as long as three to four weeks. The development of local irritation is occasionally troublesome after such an injection however. Further, most of the diseases amenable to cortisone therapy are of a generalized nature and should be treated as such.

Cortisone acetate should be given every six hours orally. The proper dose, at least initially, is that dose which will produce the desired immediate therapeutic effect and should be pushed upward with this in mind. This dose may vary from 100 to 400 milligrams daily.

The least troublesome mode of administration of cortisone would seem to consist of an initial dose sufficiently high to produce the desired effect (usually 200 to 300 milligrams daily) given for two or three days; then reduced to a less physiologically disturbing dose which will maintain remission (usually 100 milligrams daily). This reduced dose can then usually be continued for another five to seven days without undue hardship to the patient; after this period the drug may be abruptly withdrawn without fear of undue adrenal insufficiency unless the patient is subjected to particular stress at the time of withdrawal i.e. surgery, overwhelming infection or severe trauma. Troublesome side effects during this period seldom occur.

Long term use of fully or only partially effective doses of cortisone is fraught with therapeutic dilemmas including loss of effectiveness, economic hardship and bothersome to catastrophic side effects. The dilettante may well content himself with following the progress of such investigators who are already far out on the troubled sea of such a program.[3-4] Unless definitive long term curative properties of cortisone can be demonstrated the clinician should consider cortisone as highly dependable but temporizing medication.

ACUTE TOXICITY: (*IDIOSYNCRASY TO SHORT TERM ADMINISTRATION*): A lethal dose of cortisone has not been reported in the human being. Adverse symptoms appearing soon after the institution of cortisone are rare and probably represent

exuberant physiological effect of the drug in a suitably sensitive individual. Thus it is usually the patient with a history of psychiatric difficulties who develops the full blown psychotic manifestations so rapidly upon administration of cortisone. In the same manner rapidly developing forms of the expected chronic manifestations following cortisone administration will occasionally occur. No real apprehension need be felt with periods of administration and concern for contraindications as outlined above. Neither must one be concerned with withdrawal adrenal insufficiency with such a dosage schedule. The common disturbances of electrolyte balance, though occurring early, are seldom cause for immediate alarm except perhaps in those in whom it is already severely compromised.

CHRONIC TOXICITY: (*UNDESIRED PHYSIOLOGICAL EFFECTS*) The rounded, plethoric, pimply and hairy countenance of Cushings' syndrome, so long only a textbook illustration, has become commonplace in this era of long term cortisone therapy. This usually subsides on cessation of such treatment but undoubtedly leaves a mark on those who witness the spectacle. Certainly the drug should be discontinued when the patients' appearance is cause for more alarm than the disease under treatment.

Under cortisone derangement of carbohydrate metabolism with chemical features of diabetes mellitus appear, most commonly in those predisposed to this disease. Urgent use of the drug may be attempted, however, even in severe cases of diabetes mellitus provided no great increase in insulin requirement develops.

Sodium retention with development of edema, and potassium loss with generalized weakness appear in a large percentage of cases after the first week of treatment. Concurrent administration of large doses of potassium chloride (four to six grams daily) with a low sodium intake will considerably delay these effects. Overwhelming of cardiac reserve can be temporarily delayed with the use of mercurial diuretics.

The development of upper gastrointestinal symptoms, however mild, must be viewed with alarm. Indeed it is often the fortunate patient who develops such symptoms rather than blandly perforating a viscus. Some reliance may be placed upon parasympatholytic drugs and time honored peptic ulcer management though with the possibility of peptic ulcer formation becoming manifest it would seem foolhardy to push the drug, unless the indication is suitably urgent.

Undoubtedly active pulmonary tuberculosis undergoes further exacerbation with significant doses of cortisone. This does not, however, seem to be the case in Addisons' disease with active pulmonary tuberculosis, though relatively small doses of cortisone are necessary in this disease.

Minor disturbances in mood with restlessness and insomnia may accompany long term use of cortisone though the mental changes produced are usually a desirable improvement of mood and psychomotor innervation.

Excessive loss of tissue nitrogen, with suppression of tissue protein synthesis leading to muscle weakness and osteoporosis are undoubtedly cause for considerable concern after continued use of cortisone. One can be easily impressed with the magnitude of these changes upon encountering an older person abandoned to an interminable course of cortisone who suddenly shrinks several inches as the result of collapsing vertebrae[5]. Possibly anabolic hormones such as testosterone, estrogens or both will delay this effect but this is, at the best, an uncertain crutch. In younger persons and in those with terminal states this risk may assume other proportions.

Demands are frequently made upon the physician to continue cortisone beyond the limits of his better judgment. Surely, proper orientation of the patient and his family prior to therapy should be attempted. Such matters as the cost, expectations and limitations of treatment and matters of undesirable physiological effects should be mentioned. Use of the drug only when necessary and when other forms of treatment are ineffective will, of course, prove less troublesome in this regard.

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CLINICAL PATHOLOGIC CONFERENCE

The University of Oklahoma
School of Medicine

Presented by the Departments of
Pathology and Surgery

Howard C. Hopps, M.D., and
Patrick S. Nagle, M.D.

DOCTOR HOPPS: Our case today concerns an age group which most of you are or will soon be personally interested in. Although the nature of the disease process represented here seems rather obvious, the etiology and pathogenesis of this process is not quite so clear. To determine just the circumstances and the chain of events which finally led to death of this patient, we have with us Doctor Nagle whose factual information in this case is limited to the data which has been presented to each of you.

PROTOCOL

Patient: 38 year *Negro Male.*

Chief Complaints: 1) Vomiting blood. 2) "Fainty" spells.

Present Illness: The patient was irrational and the history was obtained from his wife. For several years the patient had been a chronic alcoholic, consuming "a pint or so" of whiskey per day. During the past 10 or 12 months he had complained of "gas on his stomach". He had suffered rather severe epigastric pain at times, particularly at night. This was frequently associated with sour eructation. He could occasionally obtain relief by taking Sal Hepatica. He had apparently taken no other medication. His wife believed that taking food made the pain worse. For two or three weeks before admission the patient had been drinking heavily. During the week before admission he had coughed frequently, producing small amounts of "white phlegm". Four days before admission he began having stools without any particular pain. Two days later he vomited "coffee grounds" material and began to have brief "fainty spells" with marked weakness. The following day he began to vomit considerable quantities of bright red blood. On the evening of admission he complained of severe epigastric pain. He was seen by his local physician who referred him to University Hospitals. A review by systems was essentially negative. There had been no known recent weight loss.

Past and Family History: Noncontributory.

Physical Examination: T. 102.6° (R); (P) 120; R. 36; BP 70/50. The patient was obese, restless and irrational. The skin was warm and dry. Mucous membranes were very pale. Respirations were of the Cheyne-Stokes variety. There was no distinctive odor to the breath. The lungs and heart were within normal limits except for a soft systolic murmur heard over the entire precordium. There was slight epigastric tenderness, but no muscle spasm. No rebound tenderness could be demonstrated. There were no masses or viscera palpable. Bowel sounds were within normal limits. Rectal examination disclosed only tarry feces. The extremities showed no edema. Babinski's sign could not be elicited.

Laboratory Data: A urine specimen taken eight hours after admission had a specific gravity of 1.026 with a faint trace of protein and 3+sugar. The centrifuged sediment contained 15-20 WBC's/h.p.f., 2-4 RBC's/h.p.f., and numerous coarsely and finely granular casts. Immediately after admission the hematocrit was 24 with 2.24 million RBC's/cu.mm., and "less than 7.5 gm. per cent hemoglobin". A short time later the leukocyte count was 15,700/cu.mm., and differential revealed 80 per cent polymorphonuclear leukocytes (20 per cent stab forms).

There were 90 polychromic normoblasts per 100 leukocytes.

Clinical Course: The patient was immediately given 1000 cc. of 5 per cent glucose in saline and 500 cc. of whole blood. Penicillin was given in doses of 100,000 u.q.3 h. Within the next six hours he was given an additional 1000 cc. of whole blood and 1000 cc. of 5 per cent glucose in water. When the 3+ urine sugar was discovered eight hours after admission a blood sugar was ordered and found to be 444 mg. per cent; the CO_2 combining power 56 vol. per cent. The NPN was 109 mg. per cent. About nine hours after admission a Levine tube was passed and 150 cc. of milky curds were removed from the stomach. Despite all efforts the patient remained in shock—only on one occasion was the systolic blood pressure over 100. He died about eleven hours after admission, never regaining rationality.

CLINICAL DIAGNOSIS

DOCTOR NAGLE: I'll not reread the protocol, since you have all had the opportunity to study it. The first problem to unravel here is why was this man irrational? This does not seem to fit in with the obvious hemorrhagic shock due to some gastrointestinal lesion. There is a strong temptation to reject this finding and eliminate it from consideration as a mis-statement or over-interpretation. If we do accept it and try to fit it into the diagnostic puzzle, we are left between the horns of a dilemma—to make two diagnoses, or to stretch one. We might explain the irrational state on the basis of uremia, and this is supported by an NPN of 109 mg. per cent, but I have more confidence in the clinical data than in the vagaries of laboratory interpretations, and the protocol clearly states that the breath lacked both uremic and diabetic odors. Moreover, the elevated NPN and positive urinary findings followed gastrointestinal hemorrhage and the intravenous administration of glucose and of whole blood. Although no mention is made of transfusion reaction, this must be considered, but I do not feel that the patient's irrational state was primarily due to uremia. One prefers to avoid making two diagnoses. The other alternative is to over elaborate a single diagnosis so that it will cover the entire picture. Here again helpful data is missing—no mention is made of the patient either being jaundiced or not jaundiced, and no icteric index is listed in the laboratory data. However, there is a possibility that the irrational state of the patient was due to hepatic coma secondary to extensive destruction of liver tissue by metastatic cancer, the primary site being an ulcerated and bleeding cancer of the stomach. The elevated NPN could fit in with liver failure. Also, the hemorrhagic shock and terminal picture could well have resulted from such a process.

The patient was a chronic alcoholic, consuming a pint or so of whiskey a day, and this suggests that cirrhosis of the liver with associated gastric and esophageal varices might be a cause of the patient's gastrointestinal bleeding. However, we must consider some negative aspects of this picture. A pint or so of whiskey a day does not seem like a lot of whiskey for a true alcoholic and several years does not impress me as being sufficiently long enough for cirrhosis to develop. The fact that the patient was obese indicates that he was well nourished. This too is against cirrhosis since we know that cirrhosis of the liver is not a direct effect of alcohol, but rather an effect of associated dietary deprivations. Alcoholic hepatic cirrhosis with gastric varices and hemorrhage does not seem consistent with a single, continuing, final, massive hemorrhage and it does not explain all of the findings listed here. The history of gas on the stomach from 10 to 12 months and severe epigastric pain of course suggests peptic ulcer and either duodenal or gastric ulcer could erode a vessel of sufficient size to cause a single, massive, fatal gastrointestinal hemorrhage. Statistically this is the best bet and would explain the pulse of 120, the shock-level blood pressure of 70 50 and the air hunger evidenced by a respiratory rate of 36. It is consistent too with Cheyne-Stokes respiration and with pallor. It does not explain the temperature of 102°. The lungs were stated to be within normal limits so that the fever was probably not due to terminal pneumonia. What the source of the fever is, I do not know. It could have been associated with a transfusion reaction or with urinary tract infection. A far fetched speculation would be Pel-Epstein fever associated with Hodgkin's disease of the stomach.

The sequence of events indicating gastrointestinal hemorrhage is interesting. The first of such evidence was black stools, four days prior to entering the hospital. This

blood could have come from the lower gastrointestinal tract. The next event, the vomiting of coffee grounds like substance two days before admission, indicates the source of bleeding to have been at least as high as the duodenum—this blood could have been regurgitated into the stomach. The next event, vomiting bright red blood the day before entering the hospital, suggests to me that the source of the hemorrhage was in the stomach or higher. This could have come from gastric or esophageal varices, gastric or esophageal malignancy, or gastric ulcer with erosion into an artery. I've seen extensive carcinoma of the stomach bleed over a period of days and finally produce death as a result of persistent, uninterrupted, gastric hemorrhage. Recently I saw a case in which a duodenal ulcer eroded into a good size vessel, about two mm. in diameter, the patient dying of hemorrhage in several hours. So we can have uninterrupted, continuing, massive hemorrhage from such lesions, even duodenal ulcer. We've mentioned carcinoma of the stomach but leiomyoma, a benign tumor which may occur in the stomach, sometimes bleeds profusely, and leiomyosarcoma of the stomach, an insidious tumor, may also bleed considerably.

My first choice in this case is an ulcerating gastric malignancy with continuing hemorrhage over four days, associated with extensive liver destruction, hepatic coma, and kidney failure. This fits the picture as well as any other thing I can postulate. Statistically the best bet is gastric or duodenal ulcer with hemorrhage, but that does not explain the entire picture. Cirrhosis of the liver with portal hypertension, gastric and esophageal varices with fatal hemorrhage and blood transfusion reaction is certainly to be considered.

CLINICAL DISCUSSION

QUESTION: Could the fever have been from dehydration?

DOCTOR NAGLE: I suppose it could have been caused by dehydration, but it seems a little high for this.

QUESTION: Could the elevated NPN have resulted from dehydration—so-called pre-renal azotemia?

DOCTOR NAGLE: I think that anemia and dehydration may certainly produce failure of renal function with an elevated NPN —yes.

QUESTION: Was the elevated blood sugar from I.V. administration of glucose?

DOCTOR NAGLE: Well, it is the only explanation that I can give for it. There is nothing to support even a presumption of diabetes here except the irrational state.

PATHOLOGIC FINDINGS

DOCTOR HOPPS: Doctor Nagle has pretty well localized the source of extensive hemorrhage into the upper intestinal tract. He lists three major considerations: 1) Primary malignancy of the stomach with secondary ulceration, 2) Peptic ulcer with erosion of an artery, and 3) cirrhosis of the liver with rupture of esophageal varix. I wonder how our audience feels about this? Well, it would seem that approximately 90 per cent of you believe that this is a bleeding peptic ulcer, about 10 per cent of you believe it to be cirrhosis of the liver, and perhaps one per cent are considering a malignant neoplasm of the stomach.

At the time of autopsy, foamy fluid was exuding from the patient's nose and mouth, evidence of marked pulmonary edema, usually acute pulmonary edema. Pleural cavities were essentially normal—there were no adhesions, nor excess fluid. The right lung weighed 730 gm. and the left weighed 650 gm. This increase in weight seemed to be entirely the result of edema fluid. Cut surfaces of the lungs exuded frothy watery edema fluid. This was probably related to the state of shock which this patient was observed to have clinically. The patient's obesity was quite striking—the adipose tissue layer in the anterior abdominal wall averaged 4 cm. The pertioneal cavity was free of any excess fluid and there was no evidence of inflammatory reaction or tumor. The intestinal tract was not remarkable from external gross appearance except for dark reddish purple discoloration of the colon as though it had blood in it (which proved to be the case). The liver was markedly enlarged and its margin extended 10 cm. below the costal margin in the right midclavicular line. Its surface was finely granular and presented the appearance of early cirrhosis along with marked fatty change—a change that is frequently seen in chronic alcoholism.

When the gastrointestinal tract was opened, careful exploration of the esophagus and cardia revealed no evidences of varicosities nor was there any other evidence of portal hypertension. Eight cm. from the pyloric ring, on the lesser curvature, there was an ulcer 3.5x2.2 cm. and in the center of this ulcer there projected a short nubbin of ar-

tery which was, at this time, filled with thrombus. This ulcer appeared to be subacute—its edges were fairly sharp and its margin was not markedly thickened. There was no blood in the stomach, nor was there blood in the duodenum or small intestine, but the large intestine was filled with tarry feces. It appeared that the gastric hemorrhage had been arrested shortly before death allowing the stomach and small intestine to become cleared of blood, but with tarry feces and blood still remaining in the colon. Frequently in the final stages of exsanguinating hemorrhage, as the blood pressure falls to lower and lower shock levels, there may be cessation of bleeding. It appears that such was the case here. Certainly the thrombus in the gastric artery was very recent and there was no other source of gastrointestinal hemorrhage evident.

Other pathologic findings were more or less incidental. The heart weighed 440 gm., which is a slight increase over normal. The kidneys weighed 200 and 210 gm. respectively and there was bulging of the cut surfaces, indicative of parenchymatous degeneration. There was no evidence of such primary disease as pyelonephritis, etc., to explain the elevated NPN. I think Doctor Nagle was correct in attributing this to something other than primary renal disease. A logical explanation would be that the elevated NPN resulted from absorption of increased amounts of nitrogenous material (blood) from the intestinal tract. Dehydration, shock, and acidosis would have contributed to the azotemia by reducing glomerular blood flow.

Our final pathologic diagnosis is:

Peptic ulcer, gastric, subacute, with protruding thrombosed artery in crater and with evidence of massive hemorrhage into the intestinal tract

Hyperemia and edema of lungs, marked (manifestation of hemorrhagic shock, clinical diagnosis)

Fatty change of heart and kidneys, moderate

Lipid depletion of suprarenal glands

Fatty change of liver (l.v. and s.v.) marked,—early cirrhosis, fatty type (clinically, marked chronic alcoholism)

Obesity, marked, with adipose tissue infiltration of many viscera

DISCUSSION

QUESTION: Is there any difference in the color of blood found in the intestinal tract, depending upon whether it comes from an esophageal varix or from a peptic ulcer?

DOCTOR HOPPS: No. The color of the blood depends upon the length of time it has been exposed to digestive ferments. A massive hemorrhage from peptic ulcer can give red blood in the stool if it goes through the intestinal tract fast enough, and often mass peristaltic action is stimulated by a large hemorrhage in the stomach. Similarly with bleeding from an esophageal varix. Hemorrhage of either type can lead to vomiting of bright red blood or coffee-grounds like material, depending upon how long the blood remains in the stomach before it is vomited.

QUESTION: What part did the patient's cirrhosis play in this over all picture?

DOCTOR HOPPS: I should have commented further upon that. The cirrhosis was in an early stage and had not lead to any demonstrable effects of portal hypertension. Certainly the patient's hepatic reserve was decreased and this may have brought about some heightened susceptibility to the effects of hemorrhage which in this case culminated finally in irreversible shock.

QUESTION: Could the lipid depletion of the suprarenal gland be related to the state of malnutrition?

DOCTOR HOPPS: No. This is an acute phenomenon which I think is a part of the general adaptation syndrome which is an expression of shock. It is something that can come about quickly, in a matter of some hours.

QUESTION: Would his prognosis have been improved had he been given cortical extract?

DOCTOR HOPPS: I think it is unlikely that such therapy would have helped appreciably. Would you like to close our discussion, Doctor Nagle?

DOCTOR NAGLE: This man's chronic alcoholism was very likely a factor in his gastric ulcer. On the basis of his history, we have every reason to suspect that this was not his first ulcer. Alcohol, as you know, is one of the most potent secretagogues for hydrochloric acid. It's almost as good as histamine. Many people with a tendency of hypersecretion of hydrochloric acid get in trouble when they drink alcohol. In this group, gastric bleeding may be precipitated by alcohol. The ulcer that we have seen demonstrated in this case is certainly compatible with the history of bleeding for several days.

Special Article

THE ANNUAL STATE MEDICAL ASSOCIATION MEETING AND MANUSCRIPTS FOR THE JOURNAL

As the New Year approaches, the Annual Meeting of the Association looms in the offing. The Scientific Work Committee has been appointed. Soon plans for the program will be completed. Contributors and essayists must be selected.

Those who accept assignments on the program must assemble, appraise and arrange data whether it be clinical or otherwise. The arrangements for presentation at the meeting will vary with contributors and it may be quite different from the arrangement for publication in the Journal. For publication, there should be a careful choice of words to make up short, well rounded sentences crowded into appropriate short paragraphs.

Every physician needs discipline in writing. The cultivation of words and their use in scientific communication can become an interesting pursuit. It's a sort of creative adventure resulting in genuine satisfaction if persistently pursued.

Dr. W. R. Bett[1] has said, "With the gradual decline of a classical education there is no longer that wide acquaintance with, and respect for, the meaning of words." He recommends retreating into the quiet backwaters of reflection where the friendship of words should be cultivated.

Those who contemplate preparing manuscripts for the Journal should carefully read the instructions in the fourth, fifth and sixth paragraphs under the Journal masthead Page IV. Having read these paragraphs, it should be remembered that brevity is imperative. Readers of the Journal haven't time for something said in two sentences that might be said as engagingly and effectively in one. Yet we must remember that while "Revealing brevity is fine, concealing brevity is asinine."

As a rule it's advisable to briefly give your reason for writing and possibly references to other publications on the subject Try to make what you say as interesting as possible. Medicine clothed in well chosen words need not be dull. Osler, Holmes, Moynihan many others have proved this. Give the main body of your paper careful attention and see that your facts are properly arranged, clearly presented with logical conclusions.

Every scientific paper should close with a summary. In a few words you should give the reader a comprehensive picture of what your paper contains. Your references should be properly listed and checked for accuracy. This is the way to help yourself, your readers and your Editor.

1. The Preparation and Writing of Medical Papers for Publication. W. R. Bett, M.R.C.S., L.R.C.P., F.R.S.L. Menley and James, Limited. 123 Coldharbour Lane, London, SE5. 1952.

(The Council on Pharmacy and Chemistry of the American Medical Association has adopted the following statement which appears in New and Nonofficial Remedies, 1953, Philadelphia, J. B. Lippincott Company, pp. 171-173, 1953.)

Methantheline Bromide.—*Banthine Bromide (Searle)*

β-Diethylmethylaminoethyl 9-xanthenecarboxylate bromide

Actions and Uses.—Methantheline bromide, a parasympatholytic agent, produces the peripheral action of anticholinergic drugs such as atropine and the ganglionic blocking action of drugs such as tetraethylammonium chloride. Tolerated amounts of methantheline bromide exert side effects typical of atropine-like drugs, but cause less tachycardia, and also cause less postural hypotension than does tetraethylammonium chloride. Toxic doses produce a curare-like action at the somatic neuromuscular junction.

Clinical studies indicate that the drug effectively inhibits motility of the gastro-intestinal and genito-urinary tracts and, to a variable degree, diminishes the volume of perspiration and salivary, gastric, and pancreatic secretions. It also decreases mucoprotein secretion. Like atropine, it produces mydriasis and cycloplegia when applied locally to the eye or administered systemically, but until more clinical evidence becomes available, its local use for this purpose is not recommended. The value of the drug for preventing abnormal cardiac reflexes through the vagus during thoracic surgery, or as an agent for routine preoperative medication in place of atropine, requires further investigation before final conclusions can be reached.

Methantheline bromide is indicated for clinical use whenever anticholinergic spasmolytic action is desired, provided it is not contraindicated because of its atropine-like characteristics or because of a patient's intolerance to the unavoidable side effects of such therapy. It is useful as an adjunct in the management of peptic ulcer, chronic hypertrophic gastritis, certain less specific forms of gastritis, pylorospasm, hyperemesis gravidarum, biliary dyskinesia, acute and chronic pancreatitis, hypermotility of the small intestine not associated with organic change, ileostomies, spastic colon (mucous colitis, irritable bowel), diverticulitis, ureteral and urinary bladder spasm, hyperhidrosis or control of normal sweating which aggravates certain dermatoses, and control of salivation.

Methantheline bromide produces some degree of cycloplegia and mydriasis in therapeutic doses and therefore should not be administered to patients with glaucoma. It sometimes decreases the ability to read fine print. Xerostomia (dryness of the mouth) is a common, sometimes transient, side effect. Urinary retention of varying degrees may occur in elderly male patients with prostatic hypertrophy, and some patients may have difficulty emptying the rectum. Patients with edematous duodenal ulceration may experience nausea and vomiting during initial administration of the drug. These patients should take only liquids during the institution of drug therapy. All patients should be advised of the possible occurrence of side effects. Overdosage sufficient to produce a curare-like action may be counteracted by prompt subcutaneous injection of 2 mg. of neostigmine methylsulfate.

Dosage.—Methantheline bromide is administered orally or parenterally by either the intramuscular or intravenous route. Parenteral administration is not advised for patients able to take the drug orally. The average initial dose for adults, oral or parenteral, is 50 mg. For patients with considerable intolerance, 25 mg. may be employed. In the management of peptic ulcer, a beginning schedule of 50 mg. three times daily before meals, and 100 to 150 mg. on retiring is suggested. However, the usual effective dose is 100 mg. four times daily, although some patients may require more or less than this amount. The dosage may be increased to tolerance, using dryness of the mouth as a guide, and adjusted to meet the individual response of patients. Maintenance dosage in peptic ulcer is usually considered to be about one-half the therapeutic level. In the management of other hypermotile or hypersecretory states, the dosage should be adjusted to the smallest amount which will relieve the symptoms. When spastic conditions are secondary to inflammatory or other organic lesions, therapy directed toward the cause should be employed whenever possible.

G. D. Searle & Co.
Powder Banthine Bromide: 2 cc. ampuls. 50 mg.
Tablets Banthine Bromide: 50 mg.

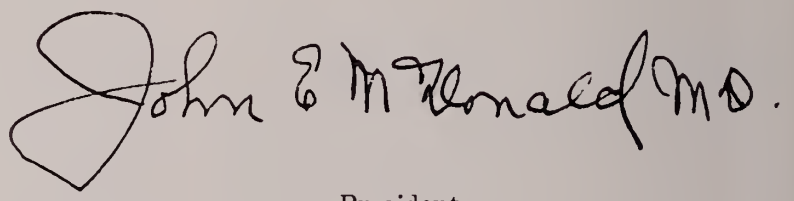
President's Page

The Spirit of Christmas permeates this entire month of December and to me there is no better time to rededicate ourselves to the service of humanity.

While Christmas in the fashion of our Christian country may not be celebrated in all parts of the world in the same fashion, there nevertheless is in the hearts of most people, the Christmas spirit. If and when the time might come that the Spirit of Christmas is forgotten, there will be little left for which to live.

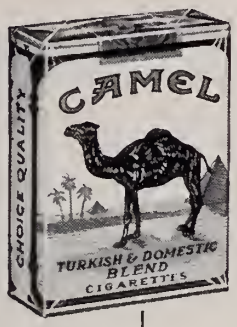
As we approach the New Year of 1954 might I suggest that each of us keep uppermost in our mind each day of the year the Spirit of Christmas.

The Spirit of Christmas is not for just a day, a week, or a year. It is a way of life.



President

FORTY YEARS OF



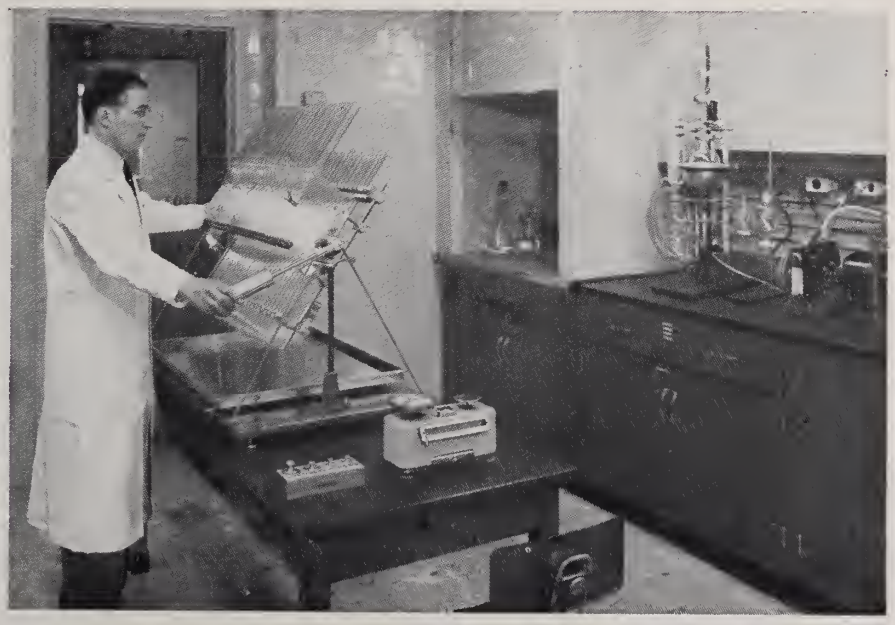
RESEARCH-PROGRESS

Camels' makers "never rest until the *good* is *better*... and the better, *best!*" For 40 years, our research has been constant, thorough, steadily progressive to make a good cigarette *better*... to make it *best*.



$2,000,000 addition to Camels' facilities — this new research building of ultra-modern laboratories.

Every laboratory equipped with the most modern research apparatus known today. (Right — "counter current" device that speeds analytical ingredient definition.)



R. J. REYNOLDS TOBACCO COMPANY · WINSTON-SALEM · N. C.

NOTES FROM THE EXECUTIVE SECRETARY'S OFFICE . . .

REPORT GIVEN ON GROUP MALPRACTICE POLICY

In response to a communication from the Executive Office, the following report has been received from the St. Paul-Mercury Indemnity Company concerning their present attitude with regard to the Association's group malpractice policy. The report was submitted by Mr. John C. Parish, secretary of the company.

Company Attitude

As a whole, the St. Paul Companies have been most pleased with the program with the Oklahoma State Medical Association and the Companies believe it has been beneficial to the insurance company as well as the Association . . . the collateral business upon which we had set our hopes in the first phases of the program has not been forthcoming in anywhere near the volume anticipated . . . To insure the company of a successful continuity of their program, the collateral lines must be recognized as an important factor in the ultimate success expected of the program. While the experience to date has been satisfactory, it isn't difficult to foresee the effect of the two or three large claims on our present annual premium volume of approximately $70,000 . . . It can be readily understood that it takes only a relatively few number of claims to exceed a permissible loss ratio of 51 per cent for this coverage.

Oklahoma Experience vs. Other States

The Oklahoma experience for 1952 indicated premiums written in an amount of $47,323, with $7,045 in incurred losses produces a 15 per cent loss ratio. During the first six months of 1953, the Companies wrote $38,049 in premiums, with $2,024 in losses, or approximately a six per cent loss ratio . . . The State of Oklahoma loss ratio for the Medical Association for 1952 was 15 per cent as compared to a national average of approximately 77 per cent. The first six months of 1953 with its six per cent loss ratio compares to a national figure for the first six months of 44 per cent. It is unwise to be overly optimistic in a comparison of this kind by states, for the effect of a single loss can cause a complete reversal of this present satisfactory picture. As a matter of illustration, since the six months' figures were prepared, a $10,000 claim has been presented, and a second claim that has had a reserve of $1500 has been increased to $4500.

General Comments on Coverage

Breakdown of the limits carried by doctors:

$ 10/ 30,000	29 per cent
15/ 45,000	4 per cent
20/ 60,000	7 per cent
25/ 75,000	27 per cent
50/150,000	28 per cent
100/300,000	4 per cent
150/500,000	1 per cent

. . . The problem of partnerships is a matter which should be given some real thought, particularly in regard to the Oklahoma program. We have many times recommended the insuring of partnerships under one policy, insuring the doctors individually and as co-partners. We have met opposition to this plan in that we should issue a separate policy for each doctor, and some doctors have insisted on such a procedure. We have also found, for various reasons, partnership liability has been excluded at the request of the doctors. Conceivably this could represent a serious gap in coverage . . . The same can be said for clinical groups, as it is important that the group under whatever name it be operating be also named as an insured in the policy.

General Attitude of Companies Writing This Business

It has become increasingly evident that insurance carriers who have been recognized as a source for Professional Liability coverage are gradually withdrawing or limiting their activities in this field. Some of the devices they employ to reduce their writings are withdrawal from certain areas entirely, the expansion of a prohibitive list of classifications in the medical profession which will not be written, the discontinuance of accepting business on a brokerage basis where collateral lines of the doctor are not available. Many companies are limiting the amount of insurance that they will write and are allowing only low limits of liability. We do not have at our disposal the national average on loss ratios, but it is obvious to us that because of the declining market for Professional Liability Insurance and the increasing rate structure, that we are dealing with a class which is in a critical situation insofar as the market is concerned.

Oklahoma Experience

Our Oklahoma experience is represented by the following figures from the years 1946 to approximately the first nine months of 1953.

	Net Premiums	Incurred Losses	Ratio
To date	$57,000	$23,000	40 per cent
First six months of 1953	38,049	2,024	6 per cent
1952	47,323	7,045	15 per cent
1950	4,514	528 cr.	0
1949	978	950	61 per cent
1948	3,349	125	4 per cent
1947	1,102		0
1946	495		0

A.M.A. ISSUES NEW PAMPHLET

Be on the lookout for a new pamphlet issued by the American Medical Association. It is attractive, easy to read and is a ready reference of the many activities of the A.M.A. and how it can help you both from a scientific and from a social and economic standpoint. If you do not receive a copy of the booklet entitled, "It's Your A.M.A.", please notify the Executive Office.

ASSOCIATION ATTEMPTING TO STANDARDIZE REPORTING FORMS

At the mid-winter meeting of the House of Delegates, the Tulsa County Medical Society submitted a suggested form for the reporting of occupational diseases. Final action on this project will be taken up at the spring meeting of the House of Delegates.

ASSOCIATION PARTICIPATING IN AMA INSURANCE SURVEY

The Council on Medical Service of the A.M.A. has requested the Association to assist it in a survey being taken as to the number of physicians insured, rates charged, number of claims, number of suits, and total expenses of malpractice insurance.

The Oklahoma State Medical Association has been selected for this purpose due to the extent to which it has developed its group malpractice insurance program.

Doctor, would it be helpful to you in your practice to know that there is a food available at reasonable prices in the stores the year round having these attributes:



1. High public acceptance as to flavor and palatability—billions eaten annually.

2. One of the best of the "protective" foods with a well-rounded supply of vitamins and minerals.

3. Low sodium—very little fat—no cholesterol.

4. Sealed by nature in a dust-proof package.

5. One of the first solid foods fed babies.

6. Can be easily digested by old folks as well as infants.

7. Can be readily eaten out of hand, in milk shakes, on cereals, or in salads.

8. Can be baked, broiled or fried.

9. Can be used as an ingredient product in breads, pies, cakes and desserts.

10. Useful in bland and low-residue diets.

11. Mildly laxative.

12. May be used in the management of both diarrhea and constipation.

13. Can be used in reducing diets.

14. Can be used in high-calorie diets.

15. Useful in the dietary management of celiac disease.

16. Useful in the dietary management of idiopathic non-tropical sprue.

17. Useful in the management of diabetic diets.

18. Valuable in many allergy diets.

19. Belongs among foods useful in certain acute intestinal infections.

20. A protein sparer.

21. Favorably influences mineral retention.

22. Useful in the management of ulcer diets.

23. One of the easiest foods to eat or prepare.

FOR THE NAME OF THIS FOOD, PLEASE TURN THE PAGE



The answer is

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If you would like

1. The authority for any of the statements made on the preceding page . . .

2. Additional information in connection with any of them...

3. The composition of the banana . . .

4. The nutritional story of the banana . . .

5. Information on various ways to prepare or serve bananas.

Please feel free to write to

Director, Chemical and Nutrition Research, United Fruit Company

PIER 3, NORTH RIVER, NEW YORK 6, N. Y.

ACADEMY OF GENERAL PRACTICE SECURES OUTSTANDING SPEAKERS

Six well known guest speakers have been secured for the Oklahoma Academy of General Practice Annual Meeting to be held February 15 and 16 at the Tulsa Hotel in Tulsa, according to V. M. Rutherford, M.D., program Chairman from Oklahoma City.

Speakers will be:

William F. Guerriero, M.D., Dallas, clinical associate professor of obstetrics and gynecology, Southwestern Medical College of the University of Texas; Horace L. Hodes, M.D., New York, director of the department of pediatrics at Mount Sinai Hospital; Manuel E. Lichtenstein, M.D., surgeon at the Cook County Graduate School, Chicago; Perrin H. Long, M.D., New oYrk, chairman of the Department of Internal Medicine at the State University of New York; Carlo Souderi, M.D., outstanding Chicago orthopedist; and Harry Wilkins, M.D., Oklahoma City neurosurgeon.

Round table luncheons will be held each day and an outstanding program is being planned for the dinner Monday night, February 15. The annual breakfast will be held Tuesday morning, February 16.

ATTEND INTERIM SESSION

Attending the A.M.A. Interim Session in St. Louis the first week in December were John E. McDonald, M.D., Tulsa, Association President; Delegates James Stevenson, M.D., Tulsa, and John F. Burton, M.D., Oklahoma City; Alternate Delegate Malcom Phelps, M.D., El Reno; President-Elect, Bruce Hinson, M.D., Enid; and Executive Secretary Dick Graham.

HOUSE OF DELEGATES MID-WINTER MEETING TERMED SUCCESS

The second annual mid-winter meeting of the House of Delegates of the Oklahoma State Medical Association was held in the auditorium of the Nurses Home at the University of Oklahoma School of Medicine October 25, 1953, with more than 100 delegates present.

The program of the meeting was an innovation inasmuch as no committee reports were heard, no resolutions presented for consideration or financial business of the Association considered.

The program dealt with certain, social, economic and political problems. Appearing twice on the program was Edward J. McCormick, M.D., Toledo, Ohio, President of the American Medical Association. Doctor McCormick's discussion of the problem of non service connected disability care for veterans and the Cline Report of the A.M.A. which deals with osteopathy highlighted the session of the House of Delegates.

Other topics discussed for the House of Delegates were: "New State Laws Effecting Problems of Health —Occupational Disease, Mental Health, Narcotics," "Durham-Humphries Law," "Operation of the Oklahoma State Board of Medical Examiners," "Prepaid Hospital and Medical Coverage," "Medical Program of Civilian Defense," "Malpractice Problems and the Association's Malpractice Program with the St. Paul-Mercury Indemnity Company," "Veterans Administration Program Concerning Non-Service Connected Disabilities," "Problems and Accomplishments of University of Oklahoma School of Medicine and its Teaching Hospitals," and the "Cline Committee Report".

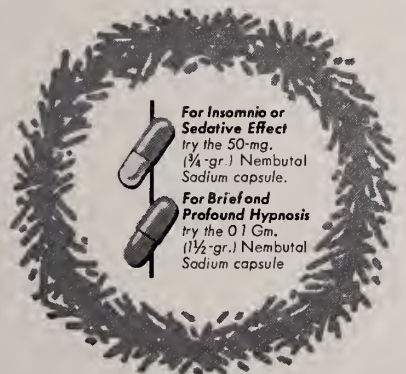
It is hoped that all deelgates who attended the meeting will make their reports to their county medical societies.



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JUSTICE DEPARTMENT CALLED IN FOR NON-SERVICE CONNECTED CASES

The Washington office of the American Medical Association has announced that it has been advised by the Veterans Administration that the Department of Justice will be called in to handle cases of suspected fraud concerning the "inability to pay" declaration of veterans with non-service connected disabilities. VA itself is forbidden by law to look behind the veteran's statement that he can't afford private treatment. According to testimony introduced in ongressional hearings, this has resulted in many abuses.

The new arrangement provides that if a VA hospital manager has good grounds to suspect that the veteran's claim of indigency is fraudulent, he will confer with federal law enforcement officials. An investigation will then be conducted by Justice Department, the regular law-enforcement arm of the federal government. If the facts justify prosecution, the case will be taken to federal court. There the government will have to prove that the veteran in question set out "preneditatedly, purposefully and intentionally" to defraud the government.

AUXILIARY CONFERENCE BEGINS FALL ACTIVITIES

Fifty-eight members of the Woman's Auxiliary to the Oklahoma State Medical Association representing 19 counties attended the fall conference at the Skirvin Hotel in Oklahoma City, October 5. Those attending the conference were state officers, county officers and chairmen.

Guest speakers were L. Chester McHenry, M.D., Oklahoma City, former President of the O.S.M.A.; Dick Graham, Executive Secretary, who reported on the public relations institute at the A.M.A., and Miss Norma Brumbaugh, state home demonstration agent from Stillwater, who reported on the Rural Health Conference.

Following the formal program, panel discussions were held after brief outlines were given by the following committee chairmen: Mrs. H. C. Wheeler, American Medical Education Foundation; Mrs. E. A. McGrew, Legislation; Mrs. T. A. Ragan, Program; Mrs. A. T. Baker, Today's Health and National Bulletin; Mrs. Gordon Livingston, Nurse Recruitment and Future Nurses Clubs; Mrs. Peter MacKercher, Doctor's Day; and Public Relations reports were given by Mrs. Edward Greenberger, Mrs. James McMurry, and Mrs. Neil Woodward, national chairman.

Other chairmen and officers giving instructions and announcements were: Organization, Mrs. Logan Spann, first vice-president and chairman; Nurse Loan Fund, Mrs. Clinton Gallaher; State Savings Bonds, Mrs. Paul Atkins; Civil Defense, Mrs. C. N. Talley; and Medical Archives, Mrs. S. D. Neely.

Officers of the Auxiliary are Mrs. M. L. Henry, President; Mrs. W. R. Cheatwood, President-Elect; Mrs. John Cunningham, Secretary; and Mrs. Charles Smith, Immediate Past President.

A.M.A. PRESIDENT IS INDUCTED INTO KIOWA TRIBE

During the meeting of the Oklahoma City Clinical Society, Edward J. McCormick, M.D., President of the American Medical Association, was inducted into the Kiowa Indian tribe. Chief Jasper Saunkeah conducted the ceremonies. Chief Saunkeah's Indian name "Doy-Om-eKach Kah-Ti-Kei" means "Chief Medicine Man."

ASSOCIATION NOTES

The Association was privileged to entertain Edward J. McCormick, M.D., President of the American Medical Association during the Oklahoma City Clinical Society . . . O.S.M.A. President John McDonald, M.D., appeared on the evening program of the Oklahoma State Nurses Association held recently in Shawnee . . . Editor Lewis J. Moorman, M.D., attended the Southern Medical Association in Atlanta; Friends of the Armed Forces Medical Library in Washington; and American Clinical and Climatological Association in Hot Springs, Virginia, in October. He was accompanied by Mrs. Moorman.

SELECTIVE SERVICE TO CALL DUAL REGISTRANTS

Selective Service has instructed local boards concerning the calling up of physicians who are registered as both a regular registrant and under the Doctor Draft Law. The following excerpt from the A.M.A.'s Washington Letter gives the details:

Selective Service has instructed local draft boards to give physicians registered both under the regular and doctor drafts 30 days in which to make application for a reserve commission, once they are called up. The agency said applicants, in applying on a form supplied by their boards, may indicate their first and second choice of service. Selective Service adds that the military department involved will notify the state director of Selective Service of any registrant who doesn't accept a commission within 30 days after it is tendered. Such registrants would then face early induction as privates.

The new instructions follow the October 8 master directive of the Defense Department implementing the revised doctor draft passed last June. The directive, among other things, clarified the status of doctors with dual responsibility, and the Selective Service instructions completed the picture. Selective Service Director Lewis B. Hershey commented: "It is the policy of the armed forces to utilize in a commissioned rather than enlisted status all special registrants who qualify for such commissions. This headquarters concurs in that policy."

EXECUTIVE SECRETARY VISITS WESTERN OKLAHOMA

Dick Graham, Executive Secretary, recently made an extensive tour over the southwestern part of the state visiting physicians and officers of county medical societies in the following communities: Clinton, Elk City, Cheyenne, Cordell, Mangum, Frederick, Waurika, Duncan, Lawton and Chickasha.

TWIN CITIES CLINIC BUILT AT HARTSHORNE

W. P. Lerblance, Jr., and D. C. Clemans, M.D., have opened the Twin-Cities Clinic at Hartshorne. The physicians remodeled a Baptist church into a modern medical center.

Both doctors have their own offices and examining rooms. There is an x-ray room and laboratory, room for diathermy treatments and central reception room which contains a television set for the benefit of patients who are waiting. The physicians plan to add a room later for minor surgery and obstetrical cases and future plans call for an electrocardigram and basal matabolism machine.

Doctor Clemans was graduated from the University of Oklahoma School of Medicine in 1952 and Doctor Lerblance graduated in 1945.

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In a review article on hormonal therapy,[1] complete relief of symptoms was reported in 62 per cent of 116 asthma patients. Another 24 per cent were made "quite comfortable." Duration of relief varied widely, with remissions occasionally lasting as long as several months. The author calls these results "truly extraordinary."

[1]Evans, R. R., and Rackemann, F. M.: *A.M.A. Arch. Int. Med.* 90:96–127, July 1952.



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FROM THE OKLAHOMA DIVISION, AMERICAN CANCER SOCIETY . . CANCER OF THE LARYNX

In the present series of 235 cases of cancer of the larynx seen at New Haven Hospital over a period of 30 years, 13 per cent had a history of cancer in one or more members of their family. Hoarseness was the most common symptom. Yet cough, decrease in general vigor, weight loss, dyspnea, and other complaints occurred frequently enough to emphasize to the general practitioner the importance of routine laryngoscopic examination of patients more than 40 years of age with these complaints. The family physician, when he has made an early diagnosis of cancer of the larynx, should without delay refer his patient to an otolaryngologist for confirmation and specific treatment. Mirror (indirect) laryngoscopy should not be relied upon to exclude cancer of the larynx. Five-year survivals in this series emphasizes the importance of early diagnosis and treatment. Predisposing factors in cancer of the larynx are listed in order of importance: (1) infections of the upper and lower respiratory tract and mouth, (2) industrial exposures, (3) excessive tobacco, (4) excessive alcohol, (5) septal deviations with obstruction, and (6) pulmonary tuberculosis.

MEDICAL EDUCATION FOUNDATION MAKES YEAR END REPORT

The American Medical Education Foundation urges all physicians who can contribute to the fund for assessed medical schools to do so by January 1.

All states except 15 are showing a net loss in contributions for 1952.

Funds collected from physicians are matched by monies raised from sources outside the medical profession. Contributions from Oklahoma are 50 per cent less than in 1952.

SEMINAR SLATED

The eighth annual University of Florida Midwinter Seminar in Ophthalmology and Otolaryngology will be held at the Sans Souci Hotel in Miami Beach the week of January 18, 1954. The lectures on Ophthalmology will be presented on January 18, 19 and 20, and those on Otolaryngology on January 21, 22 and 23. A midweek feature will be the Midwinter Convention of the Florida Society of Ophthalmology and Otolaryngology on Wednesday afternoon, January 20, to which all registrants are invited. The registrants and their wives may also attend the informal banquet at 8 p.m., on Wednesday. The seminar schedule permits ample time for recreation.

ATTEND JOURNAL CONFERENCE

Two representatives of the *Journal of the Oklahoma State Medical Association*, John Hart, Associate Business Manager; and Miss Mary Lou Crahan, Editorial Assistant, attended the State Journal Conference held at A.M.A. headquarters in Chicago November 9 and 10. The conference was sponsored by the State Journal Advertising Bureau of the American Medical Association for editors and business managers or their representatives of all state medical journals. The State Journal Advertising Bureau is the agency that develops the national advertising for the *Journal of the Oklahoma State Medical Association*

HAVE YOU HEARD?

Eugene R. Flock, M.D., has recently moved to Atoka from Stigler. He is associated with *A. C. Fina, M.D.*, in the Fina-Flock Medical Clinic in Atoka.

T. D. Benjegerdes, M.D., has recently moved from Beaver to Alva.

Maurice Fuquay, M.D., Hugo, is serving a residency in surgery at the Mayo Clinic, Rochester, Minn.

L. S. Willour, M.D., was elected to the 33rd degree of Masonry in Washington, D. C., recently.

W. W. Cotton, M.D., Poteau, was recently featured in the "Know Your Neighbor" column in the LeFlore County *Sun*.

Lin Alexander, M. D., Okmulgee, has received an award of merit from the University of Tennessee Medical College.

Ed Calhoon, M.D., 1951 graduate of the University of Oklahoma School of Medicine, has recently opened his office in Beaver.

Malcom Phelps, M.D., El Reno, represented the Association on the recent Industrial Tour that visited several eastern states to encourage industries to expand into Oklahoma.

NEW HOSPITAL OPENED AT BEAVER

Beaver county's new $400,000 hospital at Beaver has been opened and approximately 1,100 persons attended the open house.

The hospital includes x-ray room and laboratory, operating room, delivery room, nursery with new plastic clear cribs and incubator, kitchen and private and semi-private rooms. There is also a sunroom for patients.

Corridors and rooms are walled in tile and patient rooms are painted in pastel shades.

F.A.C.S. INITIATES

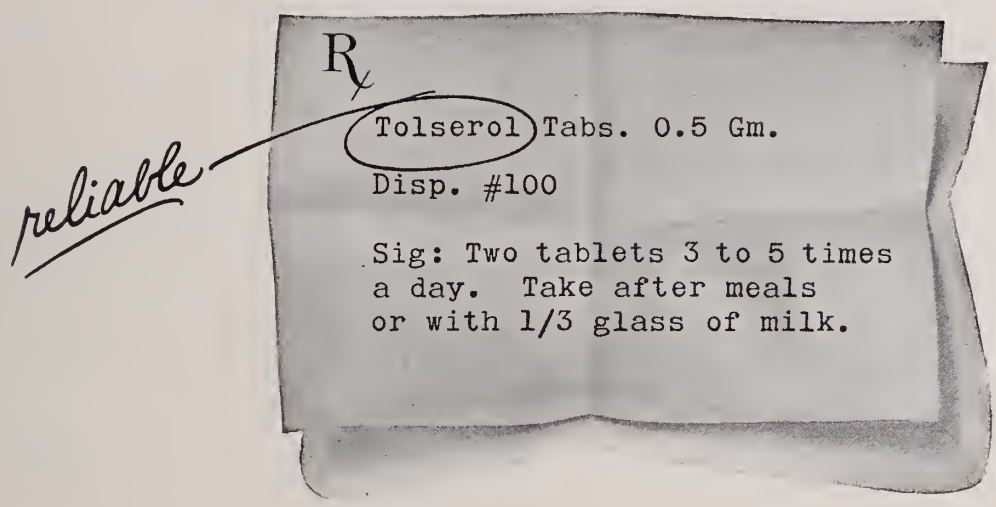
Eight Oklahoma physicians were initiated as Fellows of the American College of Surgeons October 9 at the 39th Annual Clinical Congress held in Chicago. They are:

Robert L. Anderson, M.D., Tulsa; Richard A. Clay, M.D., Oklahoma City; John Furman Daniel, M.D., Oklahoma City; Fred T. Fox, M.D., Lawton; John D. Ingle, Oklahoma City; Edmund H. Werling, Pryor; and Harold A. White, M.D., Tulsa.

OKLAHOMA CITY HOST TO ICS REGIONAL MEETING

A regional meeting of the International College of Surgeons is scheduled for January 22-23 at the Biltmore Hotel, Oklahoma City. Guest speakers representing the various surgical centers will appear on the program. A large attendance of surgeons, particularly from the states of Kansas, Texas, Louisiana, Arkansas and Oklahoma, is expected. The founder and general manager of the International College of Surgeons, Max Thorek, M.D., of Chicago, will be present.

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Complete information on the use of Tolserol in muscle spasm of rheumatic disorders, in neurologic disorders and in acute alcoholism is available from the Professional Service Department, Squibb, 745 Fifth Avenue, New York 22, N. Y.

SQUIBB

OBITUARIES

HIRAM GILL CAMPBELL, M.D.

1872-1953

Hiram Gill Campbell, M.D., Tecumseh, died October 2 at the home of his cousin, Mrs. W. F. Hereford, Lebanon, Tennessee, following a heart attack.

Doctor Campbell had been visiting in Tennessee where he was honored by the University of Tennessee for his 50 years in medical practice. He was the top medical honor student of that University when he graduated in May, 1903.

Honored last spring by the Pottawatomie County Medical Society for his half century of service, Doctor Campbell came to that county in 1907, locating at Asher. Later he moved to St. Louis and came to Tecumseh about 10 years ago. He was born in Sharp County, Arkansas, and started practicing at the age of 31 in Newport, Arkansas.

He was a member of the Broadway Methodist church, past president of the Tecumseh Rotary Club, Chamber of Commerce, Tecumseh Lodge 69 AF and AM and OES chapter 30.

J. W. FRANCIS, M.D.

1881-1953

J. W. Francis, M.D., Perry, died October 1 at his home of a heart ailment.

He was active in medical organizations and was a former president and secretary of his county medical society.

G. G. HARRIS, M.D.

1887-1953

George Gano Harris, M.D., Helena, died September 30 in Enid where he was making a call.

Doctor Harris was born in Dallas and had practiced in Helena since 1927. He was a 1917 graduate of the University of Oklahoma Medical School. During World War I, Doctor Harris served as a first lieutenant in the army medical corps.

Doctor Harris was active in medical organizations and also belonged to the Masons, the Helena chamber of commerce and the Christian church.

Lillian Robinson, M.D., Enid, is among the survivors who include the widow of the home, a son, foster-daughter, brother, two sisters and five grandchildren.

VETERANS PROBLEMS AIRED AT DALLAS CONFERENCE

Sponsored by the American Medical Association, a regional conference was held in Dallas, Texas, November 6 to discuss veterans' problems with an emphasis on the handling of non-service connected disabilities. Representatives from Oklahoma, Texas, Arkansas, Louisiana and Mississippi were in attendance.

Attending from Oklahoma were John E. McDonald, M.D., Tulsa, O.S.M.A. President; R. Q. Goodwin, M.D., Oklahoma City, Chairman of the Public Policy Committee; Lewis Carroll Taylor, M.D., Oklahoma City, representing the Oklahoma County Medical Society; and F. R. First, M.D., Checotah, representing the East Central Medical Society.

IAN MacKENZIE, M.D.

1903

Ian MacKenzie, M.D., prominent Tulsa Orthopedist, died October 12 of injuries received in an automobile accident one week previously.

Doctor MacKenzie was active in medical organizations and the Masonic order. He was founder of the Tulsa polio center.

WILLIAM C. McCLURE, M.D.

1909-1953

William C. McClure, M.D., Oklahoma City, was killed September 24 in an automobile crash near Panhandle, Texas.

Doctor McClure received his M.D., degree from the University of Oklahoma in 1936. He served on the staff of a Boston, Mass., hospital until 1939 when he began practicing in Oklahoma City. From 1942 to 1946, he was a lieutenant commander attached to the marines and participated in assault landings in the South Pacific.

In addition to other medical organizations, he was active in the Osler Society and the Oklahoma City amateur radio club.

HORACE REED, M.D.

1877-1953

Horace Reed, M.D., long time Oklahoma City surgeon, died October 7 of a heart ailment.

Born in Putnam county, Tennessee, Doctor Reed was a graduate of the University of Missouri School of Medicine, studying later at the University of Vienna. In 1901 he moved to Oklahoma, settling in Guthrie. He moved to Oklahoma City in 1908 and practiced there until January of 1953 when he retired. Doctor Reed was associated with the University of Oklahoma School of Medicine until 1936, holding the title of Professor of Clinical Surgery.

He was a past president of the Oklahoma City Academy of Medicine, Oklahoma County Medical Society, and a former delegate to the A.M.A.

GRIEVANCE COMMITTEE HARD AT WORK

The Grievance Committee, composed of the last five presidents of the Association, has been busy considering cases and during the last 60 days it has recommended to two county medical societies that disciplinary action be taken against a member of their societies.

Recommended action has already been taken by one society and is under consideration by the other.

PPast presidents now on the Grievance Committee are: A. R. Sugg, M.D., Ada; L. Chester McHenry, M.D., Oklahoma City; Ralph McGill, M.D., Tulsa; George H. Garrison, M.D., Oklahoma City; and C. E. Northcutt, M.D., Ponca City.

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MEDICAL TAPE RECORDINGS AVAILABLE IN OKLAHOMA

A new means of bringing the lecture hall to the physician unable to attend the lectures is provided by the new medical Tape Recording Library approved by the Council of the Oklahoma State Medical Association to operate on a non-profit basis. Many important meetings and postgraduate courses in Oklahoma for the past year have been recorded and it is contemplated that several national meetings will be tape recorded by this service in the future.

Recordings are distributed by the Srigley-Randels Clinic, Hollis, Oklahoma. A nominal rental fee is charged to cover operating costs. Other medical recording libraries in operation are the SOS GP Library, 286 W. McMicken Ave., Cincinnati 14, Ohio, and Audio-Digest, 404 E. Broadway, Glendale, Calif.

Asterisks adjoining each recorded lecture listed below indicate the weekly rental costs which are as follows: one asterisk, 50 cents; two asterisks, $1.00; and three astericks, $2.00 (plus postage, insurance fees and any special handling that might be necessary). A charge of $5.50 is made if the tape is lost or not returned in 30 days. Transcribing machines must be provided by the person or group ordering the tape.

Tapes now available through request to the Executive Office or Robert S. Srigley, M.D., Hollis, Oklahoma are:

Internal Medicine Postgraduate Course
May 8-9, 1953
University of Oklahoma School of Medicine
University Hospital, Oklahoma City

** Tape 1.
1. The Relation of Life Stress to Hypertension With Special Reference to Hemodynamics.
Harold G. Wolff, M.D., New York.

** Tape 2.
1. Arteriosclerosis and Hypertension.
Robert H. Furman, M.D., Oklahoma City, Okla.
2. Headache Mechanism with Special Reference to "Hypertensive Headache." (Cont'd. on Tape 3.)
Harold G. Wolff, M.D., New York.

** Tape 3.
2. Headache Mechanism with Special Reference to "Hypertensive Headache." (Cont'd. from Tape 2).
Harold G. Wolff, M.D., New York.
1. Management of Hypertension (Followed by Questions and Answers).
Robert H. Bayley, M.D., Oklahoma City, Okla.

** Tape 4
PANEL DISCUSSION
1. Illness in Older Patients.
Walker Morledge, M.D., Oklahoma City, Okla.
William K. Ishmael, M.D., Oklahoma City, Okla.
Gregory Stanbro, M.D., Oklahoma City, Okla.
Harold G. Wolff, M.D., Oklahoma City, Okla.

* Tape 5.
1. Tuberculosis.
Richard M. Burke, M.D., Oklahoma City, Okla.

* Tape 6. Fungus Disease of the Chest.
P. M. McNeill, M.D., Oklahoma City, Okla.

** Tape 7. Reaction to Threat (Cont'd on Tape 8.)
Harold G. Wolff, M.D., New York

** Tape 8.
1. (Cont'd from Tape 7.) Reaction to Threat.
Harold G. Wolff, M.D., New York.
2. Review of X-Rays on Chronic Chest Conditions.
Simon Dolin, M.D., Oklahoma City, Okla.

General Pediatrics Post Graduate Course
Tulsa, February 1, 1953
University of Oklahoma School of Medicine
Tulsa Pediatric Society
Oklahoma State Department of Health

* Tape 1.
1. Recent Developments in The Prevention and Therapy of Rheumatic Fever.
John A. Lichty, M.D., Denver, Colorado.

** Tape 2.
1. Round Table:—Problems of the Newborn and Premature Infant Infections.
John A. Lichty, M.D., Denver, Colorada.
Respiratory.
William T. Newsom, M.D., Oklahoma City, Okla.
Nutrition.
G. R. Russell, M.D., Tulsa, Oklahoma.

** Tape 3.
1. The Physician's Responsibility in Accident Prevention.
John A. Lichty, M.D.
Practical Applications of Knowledge in the Field of Growth and Development.
Henry B. Strenge, M.D.

** Tape 4.
1. Neurological Problems in Childhood (Including Convulsive Disorders.)
Robert A. Hayes, M.D., Tulsa, Okla.
2. Allergy in Childhood (Cont'd on Tape 5).

** Tape 5.
(Cont'd from Tape 4.) Allergy in Childhood.
Carroll M. Ponders, M.D., Oklahoma City, Oklahoma.
1. Symposium on Surgical Problems in Childhood (Cont'd on Tape 6.)
Orthopedics:
Charles E. Brighton, M.D., Tulsa, Okla.
Abdominal Surgery:
Thomas E. Hardman, M.D., Tulsa, Okla.

** Tape 6.
1. (Cont'd from Tape 5.) Symposium on Surgical Problems in Childhood.
Plastic Surgery:
James W. Kelly, M.D., Tulsa, Okla.
Urology:
Berget H. Blocksom, M.D., Tulsa, Okla.

Oklahoma Academy of General Practice Convention
Oklahoma City
February 16, 1953

** Tape 1.
1. Complications and Sequeallae following Cholecystecomy.
Frank R. Peterson, M.D., Cedar Rapids, Iowa.

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2. Pertinent Points on the Rheumatic Fever Problem in childhood (Cont'd on Tape 2.)
Arild E. Hansen, M.D., Galveston, Texas.
3. Custom Versus Facts in The Treatment of Peptic Ulcer.
Stewart G. Wolf, M.D., Oklahoma City.

** Tape 2.
1. (Cont'd from Tape 1.) Pertinent Points on the Rheumatic Fever Problems in Childhood.
Arild E. Hansen, M.D., Galveston, Texas.
2. Questions.
3. Fractured Ankles.
Lewis J. Levy, M.D., Fort Worth, Texas.
4. Office and Hospital Management of Infantile Diarrhea.
Arild E. Hansen, M.D., Galveston, Texas.
5. Certain Benign Lesions Having Malignant Potentialities. (Cont'd on Tape 3.)

* Tape 3.
(Cont'd from Tape 2.) Certain Benign Lesions Having Malignant Potentialities.
Frank R. Peterson, M.D., Cedar Rapids, Iowa.

** Tape 4.
1. Mumps:—Treatment and Complications in Children and Adults.
Arild E.Hansen, M.D., Galveston, Texas.
2. Poliomyelitis:—A Critical Analysis of Recent Developments.
Gordon C. Brown, M.D., Ann Arbor, Michigan.

American College of Surgeons
Oklahoma City
March 24-25, 1953

*** Tape 1.
1. Surgical Lesions of the Esophagus.
Austin H. Bell, M.D., Oklahoma City, Okla.
2. Growth Characteristics of Mammary Cancer.
John V. Goode, M.D., Dallas, Texas.

SYMPOSIUM ON TRAUMA
3. Ballistics as Related to Wound Management.
Warner F. Bowers, Colonel MC USA, Fort Sam Houston, Texas.
Responses of the Body to a Wound.
Theodore H. Nicholas, Captain MC USA, Fort Sam Houston, Texas.
5. Management of Brain and Nerve Injury.
Robert C. Hardey, Lieutenant, MC, USA, Fort Sam Houston, Texas.
6. Surgery of Thoracic Trauma.
Clinton A. Piper, Captain MC USA, Sam Houston, Texas.
7. Treatment of Abdominal Injuries.
Evan W. Schear, Major, MC USA, Fort Sam Houston, Texas.

*** Tape 2.
1. Results After Wounds of Major Arteries.
Charles C. Pixley, Captain MC USA, Fort Sam Houston, Texas.
2. Use of Intramedullary Fixation in Fresh Fractures.
Ralph E. Reiner, Colonel MC USA, Fort Fort Sam Houston, Texas.
3. Early Care of Burns by Open and Closed Methods.
William H. Amspacher, Colonel MC USA, Fort Sam Houston, Texas.
4. Backache (Cont'd on Tape 3.)

PANEL DISCUSSION
Collaborators:Basil A. Hayes, M.D., Oklahoma City, Okla.; Jess B. Herrmann, M.D., Oklahoma City, Okla.; Charles R. Rountree, M.D., Oklahoma City.

*** Tape 3.
4. (Cont'd from Tape 2.)Backache.

PANEL DISCUSSION
Collaborators: Basil A. Hayes, M.D., Oklahoma City, Okla.; Jess B. Herrmann, M.D., Oklahoma City, Okla.; Charles R. Rountree, M.D., Oklahoma City, Okla.
1. Appendicitis and Complications.

PANEL DISCUSSION
Moderator: Warren H. Cole, M.D., Chicago, Ill.
Collaborators: Charles M. O'Leary, M.D., Oklahoma City, Okla.; George B. Packard, M.D., Denver, Colorado, Richard S. Stoll, M.D., Chickasha, Okla.
2. The Diagnosis and Surgical Treatment of Congenital Hypertrophic Pylorie Stenosis.
Edward G. Donovan, M.D., New York City, N. Y.

** Tape 4.
1. Patent Ductus Arteriosus: (Movie Available from E. R. Squibb Co.)
(1) Physiology, Diagnosis and Clinical Considerations.
(2) Surgical Treatment.
George H. Humphreys II, M.D., New York City, N. Y.
2 Surgery for Massive Hemorrhage from Gastroduodenal Ulcer.
John D. Stewart, M.D., Buffalo, N. Y.
3. Prophylactic Measures in Gallbladder Surgery (Cont'd on Tape 5.)
Warren H. Cole, M.D., Chicago, Ill.

*** Tape 5.
3. (Cont'd from Tape 4.)
Warren H. Cole, M.D., Chicago, Ill.
1. Resection of Ileum and Colon in the Treatment of Chronic Granulomatous Ileocotlitis.
Harold L. Goss, M.D., Danville, Pa.
2. Hernia in Infancy and Childhood.
George B. Packward, M.D., Denver, Colo.

** Tape 6.
1. Cardiorespiratory Complications of Anethesia (Cont'd on Tape 7.)
Panel Discussion
Moderator: Lewis C. Taylor, M.D., Oklahoma City, Okla.
Collaborators: Chester McHenry, M.D., Oklahoma City, Okla.

** Tape 7.
1. (Cont'd from Tape 6.)
Cardiorespiratory Complications of Anethesia.
Panel Discussion
Moderator: Lewis C. Taylor, M.D., Oklahoma City, Okla.
Collaborators: Chester McHenry, M.D., Oklahoma City, Okla.
1. Unnecessary Pelvie Surgery.
William M. Allen, M.D., St. Louis, Mo.
2. Carcinoma of the Endometrium.
Henry G. Bennett, Jr., M.D., Oklahoma City, Okla.

Oklahoma City Obstretricaland Gynecological Society
January 17, 1953

*** Tape 1.
1. Questions and Answers.
M. Edward Davis, M.D.
2. Indications for Hysterectomy.
Joseph Kelso, M.D.
3. Endocrinology.
Arthur Hellbaum, M.D.
4. Management of an Infertile Couple.
Gerald Rogers, M. D.

* Tape 2.
The Treatment of Threatened and Habitual Abortions.
George Allen, M.D.

Southwest Clinical Conference
Tulsa
March 5, 1953

** Tape 1.
1. Resuscitation of the Newborn.
William Newsom, M.D., Oklahoma City, Okla.
2. Nutritional Disturbances of Children with Special Reference to Cystic Fibrosis of the Pancreas.
Harry Sewachman, M.D., Boston, Mass.

** Tape 2.
1. Gastric Ulceration—Benign and Malignant.
Stewart Wolf, Jr., M.D., Oklahoma City.
2. X-Ray Conference.

* Tape 3.
Uses and Abuses of Antibiotic Therapy.
Harry Shwachman, M.D., Boston, Mass.

Oklahoma City Internists Associaiton
Oklahoma City
February 19, 1953

*** Tape 1.
1. Present Concepts of Ulcerative Colitis.
Turner Bynum, M.D., Oklahoma City, Okla.
2. Newer Radiographic Technics.
Peter E. Russo, M.D., Oklahoma City, Okla.
3. New Drugs Used in the Treatment of Hypertension.
John J. Donnell, M.D., Oklahoma City, Okla.
4. Background of Anemia (Cont'd on Tape 2.)
Hugh Jeter, M.D., Oklahoma City, Okla.

*** Tape 2.
4. (Cont'd from Tape 1.) Background of Anemia.
Hugh Jeter, M.D., Oklahoma City, Okla.
1. Rheumatic Carditis.
Ben H. Nicholson, M.D., Oklahoma City, Okla.
2. Clinic—Indication for Cardic Surgery.
Robert H. Bayley, M.D., Oklahoma City, Okla.
Robert H. Furman, M.D., Oklahoma City, Okla.

Oklahoma State Medical Convention
Tulsa
April 13-14-15, 1953

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1. Management of Eclampsia
B. C. Chatham, M.D., Chickasha.
2. Present Concepts of Treatment of the Pregnant Woman in the Last Trimester with a Dead Fetus and Resulting Toxemia.
Brunel D. Faris, M.D., Oklahoma City.
3. The Closed Method of Lauge-Hansen for Treatment of Ankle Fractures.
David C. Ramsey, M.D., Ada, Oklahoma.
4. Rigid Wire Fixation of Fractures in the Hand.
Howard B. Shorbe, M.D., Oklahoma City and William L. Waldrop, M.D., Oklahoma City, Okla.
5. Treatment of Varicose Veins (Cont'd.)
John Powers Wolff, M.D., Oklahoma City, Okla.

*** Tape 2.
1. (Cont'd.) Treatment of Varicose Veins.
John Powers Wolff, M.D., Oklahoma City.
2. Middle Life and Mental Disease.
Francis J. Braceland, M.D., Hartford, Conn.
3. Bronchogenie Carcinoma.
Paul H. Holinger, M.D., Chicago, Ill.
4. Recent advances in the treatment of Portal Hypertension.
W. Alton Ochsner, M.D., New Orleans, La.
5. Radioactive Iodine 131 in the Treatment of Hyperthyroidism.
Wendell G. Scott, M.D., St. Louis, Mo.
6. Respiratory Failure During Surgery (Cont'd.)
Carl A. Moyer, M.D., St. Louis, Mo.

** Tape 3.
1. (Cont'd.) Respiratory Failure During Surgery.
Carl A. Moyer, M.D., St. Louis, Mo.
2. The Use of Pan Transfusion System.
Allan P. Bloxsom, M.D., Houston, Texas.

Practitioners Conferences
University of Oklahoma School of Medicine
Oklahoma City

***1.
Date: November 20, 1952
Panel Discussion: Duodenal Ulcer
Participants
Stewart Wolf, M.D., Oklahoma City
Turner Bynum, M.D., Oklahoma City
J. R. Colvert, M.D., Oklahoma City
B. E. Mulvey, M.D., Oklahoma City
Joe M. Parker, M.D., Oklahoma City

***2.
Date: December 18, 1953
Panel Discussion: Backache
Participants
Stewart Wolf, M.D., Oklahoma City
James Amspacher, M.D., Oklahoma City
William K. Ishmael, M.D., Oklahoma City
Harry Wilkins, M.D., Oklahoma City
Henry G. Bennett, M.D., Oklahoma City

***3.
Date: January 22, 1953
Panel Discussion: Coronary Artery Disease
Participants
Stewart Wolf, M.D., Oklahoma City
Robert H. Bayley, M.D., Oklahoma City
Robert H. Furman, M.D., Oklahoma City
W. W. Rucks, Jr., M.D., Oklahoma City
Homer A. Ruprecht, M.D., Tulsa, Okla.

(Continued in January Issue)

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Key to Abbreviations

(S)—Scientific Article
(E)—Editorial
(SA)—Special Article)
(A)—Announcements
(BR)—Book Reviews
(TC)—Therapeutic Conference
(ABS)—Abstract
(O)—Obituary
(PIC)—Picture
(GN)—General News
(CPC)—Clinical Pathologic Conference

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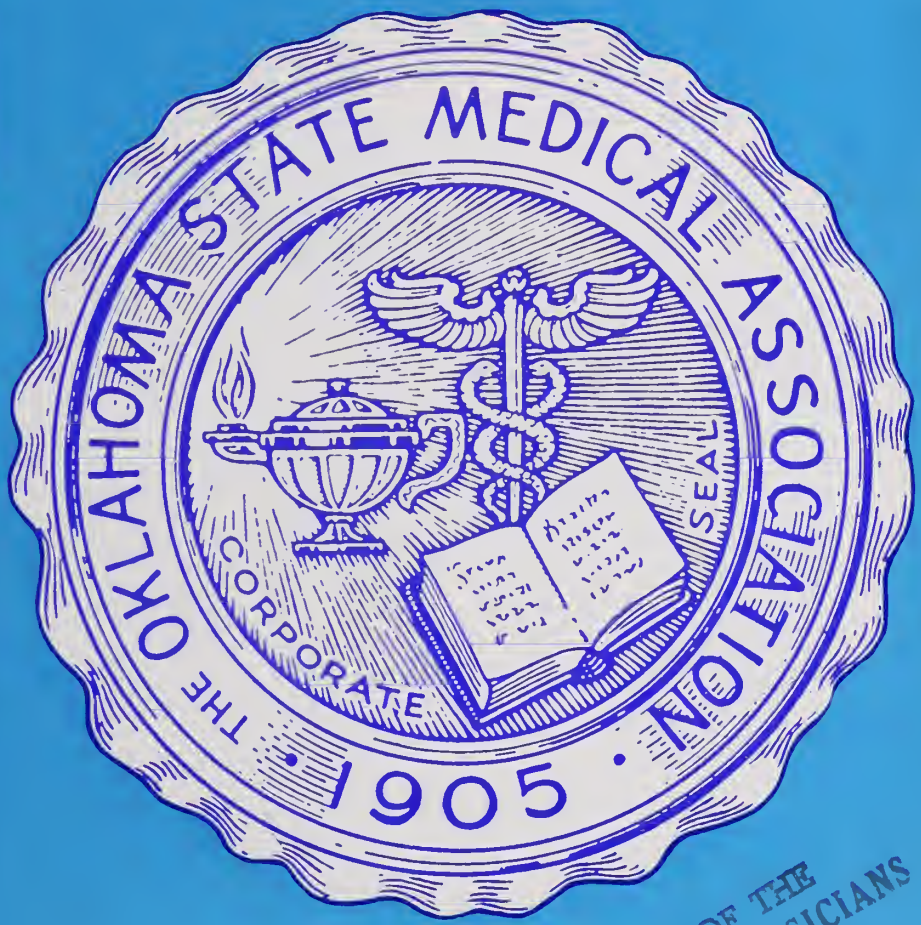
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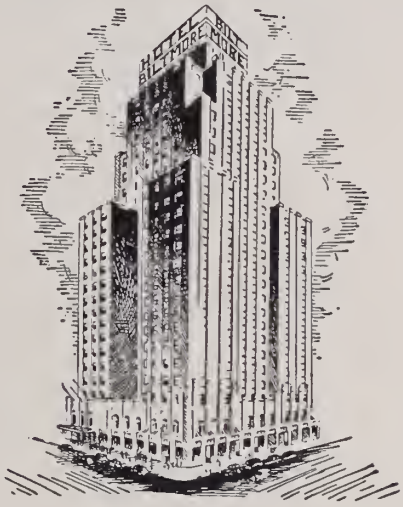
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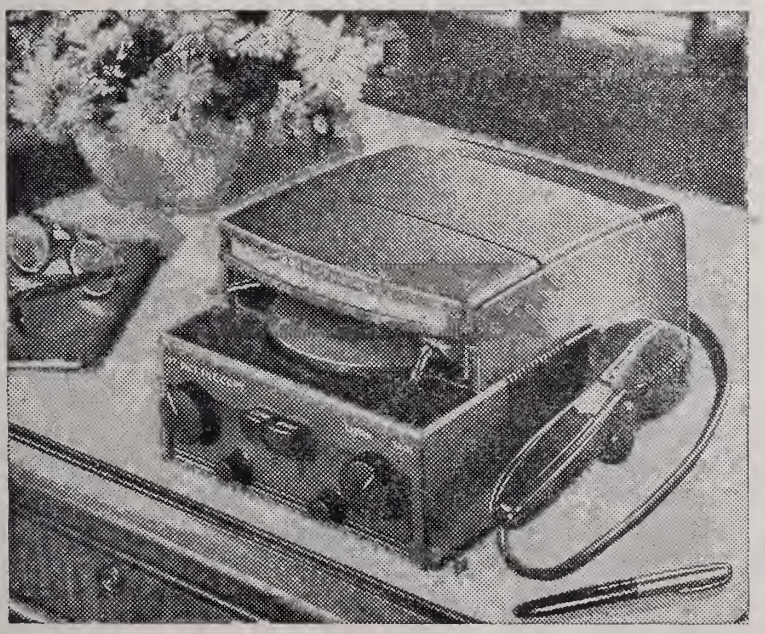
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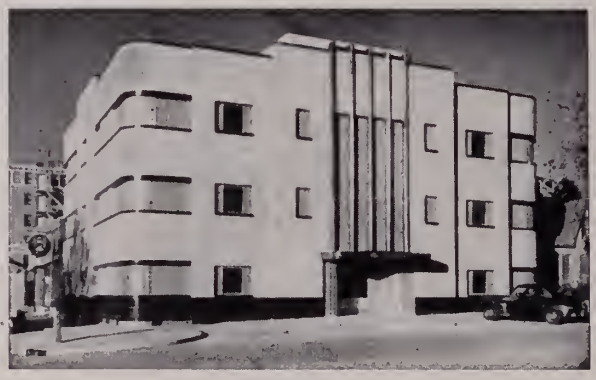


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Coker, B. B. ....Durant
Cole, W. C. ....605 Gore Blvd., Lawton
Coley, A. J. (H) (F) ....1929 N.W. Park, Okla. City
Coley, Joe H. ....416 N.W. 13, Okla. City
Collins, D. B. (L) (F) ....Waurika
Collins, E. L. (F) ....Panama
Collins, Glenn S. ....119 E. Atkinson Plaza, Midwest City
Collins, Joe Ed ....1325 S.W. 29, Okla. City
Collins, Mabelle S. ....1325 S.W. 29, Okla. City
Colvert, J. R. ....1319 Classen Drive, Okla. City
Colwick, J. T. ....Durant
Combs, Leon D. ....Shawnee
Comp, G. A. (H) ....Manitou
Connell, M. A. ....Picher
Couover, George W., Jr. ....Anadarko
Conrad, Loyal L. ....800 N.E. 13, Okla. City
Cook, C. E., Jr. ....1243 Britton Road, Okla. City
Cook, Edward T., Jr. ....Anadarko
Cook, Odis A. ....Madill
Cook, W. Albert (H) (F) ....Med. Arts Bldg., Tulsa
Cook, W. H. (L) ....Chickasha
Cooke, C. H. ....Perry
Cooke, Everette E. ....525 N.W. 11, Okla. City
Cooper, F. Maxey ....Med. Arts Bldg., Okla. City
Cooper, N. H. ....Ponca City
Coppedge, O. C. ....Bristow
Coppedge, O. S. ....Depew
Cordonnier, Byron J. ....Broadway Tower, Enid
Cosby, Glenn W. ....Miami
Coston, Tullos O. ....1111 N. Lee, Okla. City
Cotten, Daisy V. ....1111 N. Dewey, Okla. City
Cotteral, John R. ....Henryetta
Cotton, W. W. ....Poteau
Coulter, Thomas B. (L) ....Med. Arts Bldg., Tulsa
Courtright, Anne C. (AP) ....County Bldg., Okla. City
Covington, Terrell, Jr. ....Court Arcade Bldg., Tulsa
Cowling, Robert E. ....Ada
Cox, A. K. ....Watonga
Cox, J. L. ....Ardmore
Coyle, John J., Jr. ....1200 N. Walker, Okla. City
Coyner, Wallace R. ....Edmond
Craig, Paul E. ....Daniel Bldg., Tulsa
Cramblet, Denny H. ....Holdenville
Crane, Donald V. ....Med. Arts Bldg., Tulsa
Crawford, Sterling T. ....1200 N. Walker, Okla. City
Crawford, William S., Natl. Bank of Tulsa Bldg., Tulsa
Crick, L. E. ....1417 N.W. 94, Okla. City
Croom, William S. (AP) ....415 N.W. 12, Okla. City
Cronk, Gerald ....2020 S. Xanthus, Tulsa
Cronk, Robert T. (AP) ....443 N. 16, Muskogee
Crow, Emory S. (L) (F) ....Olustee
Cunningham, C. D. ....Ardmore
Cunningham, Charles S. ....Ardmore
Cunningham, C. B. ....Clinton
Cunningham, John A. ....First Natl. Bank Bldg., Okla. City
Cunningham, John H. ....Duncan
Curtin, Virginia ....Watonga
Curry, J. F. ....Sapulpa
Cushing, Vernon D. ....711 N.W. 10, Okla. City

—D—

Dague, John C. ....Tri-State Ins. Bldg., Tulsa
Daily, R. E. ....Bixby
Dakil, L. N. ....McAlester
Dakil, Samuel E. (AP) ....Wewoka
Daniel, John F. ....Med. Arts Bldg., Okla. City
Daniels, Harry A. ....610 N.W. 9, Okla. City
Danstrom, John R. ....521 N.W. 11, Okla. City
Darrough, James B. ....Vinita
Davidson, W. N. ....Cushing
Davidson, W. N., Jr. (AP) ....Cushing
Davis, Arthur H. ....Med. Arts Bldg., Tulsa
Davis, Francis A. ....Shawnee
Davis, George (J) ....1653 E. 12, Tulsa
Davis, George M., Sr. (L) ....Bixby
Davis, K. D. ....Bartlesville
Davis, Randall ....Duncan
Davis, Thomas H. ....2020 S. Xanthus, Tulsa
Davis, Wesley D. ....Chickasha
Dawson, Clarence B. ....1200 N. Walker, Okla. City
Day, John L. (L) ....Woodward
Dean, Robert E. ....Fairfax
Deau, S. C. (F) ....Howe
Dean, W. A. ....Med. Arts Bldg., Tulsa
Dean, W. F. ....Ada
Deaton, A. N. ....Wewoka
Deese, E. F. ....Ada
DeJarnette, John F., Jr. ....Geary
DeLay, W. D. ....Sulphur
Delhotal, Charles E. (M) ....Muuicipal Airport, Alexandria, La.
Demas, Ross P. ....Stroud
Deuney, Lawrence A. ....Stanolind Bldg., Tulsa
Dennis, Robert P. ....608½ "C" Lawton
Denser, John W. (AP) ....915 S. Cin., Tulsa
Denyer, H. E. ....Bartlesville
Deputy, Ross ....Cliuton
Dersch, Walter H., Jr. ....Shattuck
Dersch, Walter H., Sr. ....Med. Arts Bldg., Okla. City
DeTar, George A. ....Miami
Deupree, Harry L. ....1111 N. Lee, Okla. City
Devanney, P. J. ....Sayre
Dewberry, Glenn P. ....Clinton
Dickinson, W. Paul (M) ....c/o Postmaster, New York
Dill, Francis E. ....Med. Arts Bldg., Okla. City
Divine, Duke G. ....Wagoner
Dixon, Ambrose (L) ....Hennessey
Dixon, Robert W. ....1449 Westwood, Okla. City
Dixon, W. L. ....Cement
Dodd, Nevin W. ....1321 S. Main, Tulsa
Dodson, Harrel C., Jr. ....800 N.E. 13, Okla. City
Douaghe, Roy W. ....605 Gore Blvd., Lawton
Donnell, John J. ....525 N.W. 11, Okla. City
Donovan, Mark H. ....2120 E. 25th, Tulsa
Dorrough, Joe ....Haileyville
Dorwart, F. G. ....510 S. 11, Muskogee
Doudna, Hubert E. ....528 N.W. 12, Okla. City
Dougan, A. F. ....Broadway Tower, Enid
Dougan, A. L. (L) (F) ....Carmen
Dougherty, Raymond J., Jr. ....Perry

Downey, D. S. (L) ..... Chickasha
Downing, G. G. ..... 605 Gore Blvd., Lawton
Doyle, W. H. ..... 443 N. 16, Muskogee
Dozier, B. E. ..... Shidler
Driver, J. W. ..... Perry
Dudley, Alberta Webb ..... Box 30W, Warr Acres Branch, Okla. City
Duer, Joe L. ..... Woodward
Duffy, Francis M. ..... 211 W. Maple, Enid
Dunlap, Ernest B. ..... 513 "E" Ave., Lawtou
Dunn, J. Hartwell (M) ..... Sheppard A. F. B., Wichita Falls, Texas

—E—

Eads, Charles H. ..... Med. Arts Bldg., Tulsa
Eager, Ella L. ..... Stillwater
Earnest, A. N. ..... Barnes Bldg., Muskogee
Eastland, William E. ..... Med. Arts Bldg., Okla. City
Echols, Raymond S. ..... 1701 E. 19, Tulsa
Edwards, David L. ..... 2020 S. Xanthus, Tulsa
Edwards, J. G. ..... Okmulgee
Edwards, Martin Dale ..... 4420 S.E. 28, Okla. City
Edwards, Rheba L. ..... 4420 S.E. 28, Okla. City
Eley, N. Price ..... 1319 Classen Drive, Okla. City
Eliel, Leouard P. ..... 825 N.E. 13, Okla. City
Elkins, Marvin ..... Barnes Bldg., Muskogee
Elliott, Arthur F. ..... 807 N.W. 23, Okla. City
Ellis, H. A. (L) ..... Kiowa
Ellis, Leonard J., Jr. 4101, MacArthur Blvd., Okla. City
Ellis, Richard A. ..... Duncan
Emenhiser, Lee K. ..... 511 N.W. 11, Okla. City
Emmott, Ralph C. ..... Stilwell
Endres, R. K. (M) ..... Military Address Unknown
England, Myrou C. ..... Woodward
Engles, Charles F. (AP) ..... 1303 S.W. 29, Okla. City
Engles, Leroy L. ..... Durant
Engles, Loretta G. (AP) ..... 1303 S.W. 29, Okla. City
Euos, Jack Paul ..... Yukon
Ensey, James E. ..... Altus
Ensor, D. B. ..... Hopeton
Epley, C. O. ..... 1200 N. Walker, Okla. City
Eskridge, J. B., Jr. ..... 1220 N. Walker, Okla. iCty
Eskridge, J. B. III ..... 1220 N. Walker, Okla. City
Etherton, Monte C. ..... 10-A South Lewis, Tulsa
Etter, F. S. ..... Bartlesville
Evans, A. M. ..... Perry
Evans, Alden M. (AP) ..... First Natl. Bank Bldg., Ada
Evans, Hugh J. ..... Med. Arts Bldg., Tulsa
Evans, H. M. ..... 214 S. 4th, Lawton
Evans, Leo R. ..... Sayre
Ewell, William C. ..... 1307 S. Main, Tulsa
Everett, Mark R., Ph.D. (A) ..... 801 N.E. 13, Okla. City
Ewing, Finis W. (H) ..... Surety Bldg., Muskogee

—F—

Fagin, Hermau ..... 521 N.W. 11, Okla. City
Fair, E. Edwin ..... Med. Arts Bldg., Okla. City
Fair, E. N. ..... Heavener
Faris, Brunel D. ..... Med. Arts Bldg., Okla. City
Farr, Louise K. ..... 4030 Springlake Drive, Okla. City
Farris, Edward M. ..... 1111 N. Lee, Okla. City
Farris, H. Lee (L) (F) ..... 2214 E. 25th, Tulsa
Feamster, R. C. ..... Bellaire, Texas
Featherston, William M. ..... Elk City
Feild, Julian ..... 610 S. Monroe, Enid
Felman, E. F. (J) ..... 1923 S. Utica, Tulsa
Ferguson, E. Gordon ..... Med. Arts Bldg., Okla. City
Ferguson, Lawrence W. ..... 509 "E" Ave., Lawton
Ferraro, Douglas T. ..... 1306 E. 35, Tulsa
Fetzer, Jack D. ..... Woodward
Fife, Phillips R. ..... Guthrie
Fina, A. C. ..... Atoka
Finch, J. William ..... Hobart
First, F. R., Sr. ..... Checotah
First, F. R., Jr. ..... Checotah
First, Safety R. ..... Med. Arts Bldg., Tulsa
Fisher, Roy L. ..... Frederick
Fishman, C. J. ..... 132 N.W. 4th, Okla. City
Fite, E. Halsell ..... 443 N. 16, Muskogee
Fite W. Pat ..... 443 N. 16, Muskogee
Fite, W. Pat, Jr. (AP) ..... 443 N. 16, Muskogee
Flack, F. L. ..... McFarlin Bldg., Tulsa
Flack, Frank E. ..... Woodward
Flanigan, H. F., Jr. ..... Med. Arts Bldg., Tulsa
Fleetwood, D. H. ..... Edmond
Flesher, Thomas H. (L) (F) ..... Edmond
Florence, John ..... 1200 N. Walker, Okla. City
Foerster, Hervey A. ..... 1220 N. Walker, Okla. City
Ford, Harry C. ..... Miami
Ford, H. W. ..... 915 S. Cin., Tulsa
Foertsch, J. H. ..... Chickasha
Forester, Virgil Ray ..... 1111 N. Lee, Okla. City
Forrest, Herbert J. ..... 1419 E. 15, Tulsa
Forry, Willis W. ..... Bixby
Foshee, W. C. ..... Stillwater
Foster, Claude F., Jr. ..... 318 S.W. 25, Okla. City
Fox, Fred T. ..... 605 Gore Blvd., Lawton
Fox, William W. ..... Norman
Francis, J. W. ..... Perry
Francisco, Glenn ..... Bass Bldg., Enid
Frank, Louis S. ..... 1111 N. Lee, Okla. City
Franklin, Onis ..... Broken Arrow
Franklin, S. E. ..... 1619 E. 15, Tulsa
Freed, Leon C. ..... Perkins
Freede, Charles L. ..... 525 N.W. 11, Okla. City
Freede, Henry J. ..... 420 N.W. 13, Okla. City
Freeman, Charles W. ..... 625½ N.W. 10, Okla. City
French, Samuel L. ..... Tri-State Ins. Bldg., Tulsa
Frew, A. L., Jr. ..... 528 N.W. 12, Okla. City
Fried, David ..... Mangum
Frierson, S. E. ..... Med. Arts Bldg., Okla. City
Fry, F. Polk ..... Frederick
Fry, Powell E. ..... Stillwater
Fryer, Samuel R. ..... 511 N.W. 11, Okla. City
Fulcher, Joseph ..... 1151 S. Peoria, Tulsa
Fullenwider, C. G. ..... Barnes Bldg., Muskogee
Fulton, C. C. ..... Med. Arts Bldg., Okla. City
Funk, Robert E. ..... Med. Arts Bldg., Tulsa
Fuqua, W. A. ..... Grandfield

—G—

Gable, James J., Jr. ..... 301 N.W. 12, Okla. City
Gaddis, John W. (M) ..... Military Address Uuknown
Gaddis, Newell C. ..... 1530 S. Peoria, Tulsa
Gaflord, Thomas, Muskogee General Hospital, Muskogee
Galbraith, Ben T. ..... McAlester
Galbraith, Hugh M. ..... First Natl. Bank Bldg., Okla. City
Gallagher, C. A. ..... 610 N.W. 9, Okla. City
Gallaher, Clinton ..... Shawnee
Gallaher, Paul C. ..... Shawnee
Gallaher, William M. (F) ..... Shawuee
Gallaway, Nova Linda (AP) ..... Prague
Gardner, C. C. ..... Ponca City
Garnier, William H. ..... Stillwater
Garrett, Claude (J) ..... 1653 E. 12, Tulsa
Garrett, D. L. ..... Med. Arts Bldg., Tulsa
Garrisou, George H. ..... 1111 N. Lee, Okla. City
Gastineau, Felix T. ..... Med. Arts Bldg., Tulsa
Gathers, George B., Jr. (AP) ..... Stillwater
Gauchat, August C. (AP) ..... Shawuee
Gee, L. E. (F) ..... Broken Bow
Gee, O. J. ..... Med. Arts Bldg., Okla. City
Gee, R. L. (F) ..... Hugo
Geiger, W. A. ..... 1321 S. Main, Tulsa
Geigerman, David J. ..... 1220 N. Walker, Okla. City
Gentry, E. Lee ..... Med. Arts Bldg., Tulsa
Gentry, R. C. ..... Bartlesville
George, Ella Mary ..... 800 N.E. 13, Okla. City
Gephardt, Maurice C. ..... Vet. Adm. Hospital, Muskogee
Ghormley, J. G. ..... Blackwell
Gibbs, Allen G. ..... 521 N.W. 11, Okla. City
Gibson, R. B. ..... Ponca City
Gibson, R. W. ..... Ponca City
Gilbert, Johu B. ..... Ponca City
Gill, W. T. ..... Ada
Gillespie, C. P. ..... Norman
Gilliam, William C. (L) (F) ..... Spiro
Gillick, David (A) ..... Talihina

Gilliland, Charles E. ....Kansas City, Missouri
Gissler, Norman E. ....Okemah
Glasgow, Jack G. ....4101 N. MacArthur Blvd., Okla. City
Glass, Fred A. ....2020 S. Xanthus, Tulsa
Glasscock, Thomas C. ....Ponca City
Glasser, Samuel M. ....Will Rogers Hospital, Okla. City
Glissman, Marvin B. ....1019 N. Lee, Okla. City
Glomset, John L. ....2420 Classen Blvd., Okla. City
Goddard, R. K., Sr. ....Skiatook
Goddard, Roy K., Jr. (AP) Natl. Bank of Tulsa Bldg., Tulsa
Godfrey, James T., Jr. ....Ardmore
Godfrey, Kenneth E. ....Okeene
Goen, Rayburne W. ....Braniff Bldg., Tulsa
Goldberger, Joseph H. ....El Reno
Goldfain, E. ....228 N.W. 13, Okla. City
Gomez, Francisco (J) ....1653 E. 12, Tulsa
Goodman, George L. ....Yukon
Goodman, Samuel ....Med. Arts Bldg., Tulsa
Goodwin, R. Q. ....1111 N. Lee, Okla. City
Gordon, J. M. ....Ardmore
Gordon, Minor E. ....Claremore
Gorrell, Ben. F. ....2257 E. 32nd, Tulsa
Gorrell, J. F. ....Med. Arts Bldg., Tulsa
Gowey, H. O. ....Newkirk
Graening, P. K. ....Med. Arts Bldg., Okla. City
Graham, A. T. ....26 S.W. 25, Okla. City
Graham, Hugh C. ....1307 S. Main, Tulsa
Graham, J. A. ....Pauls Valley
Graham, Mary V. ....1306 E. 35, Tulsa
Graham, Rex M. ....Miami
Grantham, Elizabeth (H) ....Alva
Gray, Dan F. (L) (F) ....Guthrie
Gray, Floyd ....1200 N. Walker, Okla. City
Gray, John F., Jr. ....Med. Arts Bldg., Tulsa
Gray, Virgil B., Jr. ....Surety Bldg., Muskogee
Graybill, Charles S. ....605 Gore, Lawton
Graybill, R. B. ....Ardmore
Green, Burdge F. ....Stilwell
Green, Charles E. ....605 Gore Blvd., Lawton
Green, Harry ....Med. Arts Bldg., Tulsa
Green, O. I. ....Bartlesville
Greenberger, Edward D. ....McAlester
Greer, Allen E. ....1200 N. Walker, Okla. City
Gregg, O. R. ....Normau
Gregston, Jack L. ....Marlow
Grigsby, O. L. ....Nowata
Grimes, John P. ....Wewoka
Grosshart, Paul L. ....Med. Arts Bldg., Tulsa
Groves, Gene (AP) (M) ....Military Address Unknown
Grubb, Robert D. ....1306 E. 35th, Tulsa
Guild, Carl H., Jr. ....1419 E. 15, Tulsa
Guild, C. H., Sr. ....Shidler
Gullatt, E. M. ....Ada
Guthrey, G. H. ....510 N.W. 12, Okla. City
Gwartney, Warren G. ....Pryor
Gwin, Jerry B. ....Ada
Gyles, William T. ....Rush Springs

—H—

Haas, H. R. (L) ....Disney
Hackler, H. W. ....Norman
Hackler, John F. ....519 S. 3, Muskogee
Haddock, James L., Jr. ....Norman
Haddock, Phil ....Norman
Haddox, C. H. ....Pawnee
Hagg, O. J. ....Waurika
Hahn, L. A. (L) ....Guthrie
Hairston, R. M. (C) ....Chickasha
Hake, Oren J. (M) ....Military Address Unknown
Hale, A. Eugene ....Idabel
Hale, Arthur E. ....2020 S. Xanthus, Tulsa
Hale, Forrest ....Cherokee
Hall, Clark H. ....Med. Arts Bldg., Okla. City
Hall, C. H. (H) (F) ....15 W. 3rd, Tulsa
Hall, Harry B. ....Boise City
Hall, R. L. ....Bass Bldg., Enid
Hamble, V. R. ....Broadway Tower, Enid
Hamilton, S. H. ....Non
Hamm, Leslie T. ....Koehler Bldg., Lawton
Hamm, Silas G. ....Haskell
Hampton, Hollis (M) ....Military Address Unknown
Haney, T. Paul ....521 S. Boulder, Tulsa
Hansen, M. Fred, LL.B. (A) Attorney General's Office, Okla. City
Haralson, Charles H. ....Med. Arts Bldg., Tulsa
Haralson, P. H. (J) ....1923 S. Utica, Tulsa
Harber, J. N. (H) ....Phoenix, Arizona
Harbison, Edgar Frank ....425 N.W. 12, Okla. City
Harbison, J. E. (L) (F) ....1625 Marion, Okla. City
Hardman, T. J. ....Med. Arts Bldg., Tulsa
Hardy, Walter (L) (F) ....Ardmore
Hargrove, Robert D. (AP) ....Pawnee
Harkins, Richard ....McAlester
Harris, Bunn ....Jenks
Harris, Clyde E. ....2419 N. Walker, Okla. City
Harris, D. S. ....Drummond
Harris, G. G. ....Helena
Harris, Henry W. ....1200 N. Walker, Okla. City
Harris, Richard L. ....3832 N. May Ave., Okla. City
Harris, Russel D. ....605 N.W. 10, Okla. City
Harrison, Gene H. ....Seminole
Harrison, Lynn H. ....2850 N.W. 23, Okla. City
Harrison, Stearley P. ....Ada
Hart, Mabel M. ....2529 S. Boston Pl., Tulsa
Hart, Marshall O. ....1228 S. Boulder, Tulsa
Hartford, Walter K. ....1111 N. Lee, Okla City
Harvey, John H. ....Heavener
Harvey, Rosemary (J) ....1653 E. 12, Tulsa
Haskett, Paul (L) ....1941 N.W. 19, Okla. City
Haslam, G. E. ....Anadarko
Hassler, F. R. ....State Health Dept., Okla. City
Hassler, Grace C. ....1111 N. Lee, Okla. City
Hathaway, A. H. (L) (F) ....Mountain View
Hathaway, W. G. ....Lone Grove
Haugen, I. J. ....Ada
Hawn, W. T. (L) ....Binger
Hayes, Basil A. ....625 N.W. 10, Okla. City
Hayes, R. B. (L) ....Guymon
Hayes, John R. ....Shawnee
Hayne, Robert A. ....604 S. Cin., Tulsa
Haynes, W. M. ....Henryetta
Haynie, W. K. ....Durant
Hays, Carolyn C. A. ....Philadelphia General Hospital, Philadelphia, Penn.
Hays, Luvern ....2445 E. 27, Tulsa
Hays, Marvin B. ....1220 N. Walker, Okla. City
Hays, P. L. ....Vinita
Hazel, Onis G. ....Med. Arts Bldg., Okla. City
Heatley, John E. ....701 N.E. 42, Okla. City
Heflin, W. A. ....Ryan
Hellams, A. A. ....Med. Arts Bldg., Okla. City
Helibaum, Arthur A. (A) ....801 N.E. 13, Okla. City
Henderson, F. W. (L) ....1647 E. 1st, Tulsa
Henderson, William N. ....1415 E. 15, Tulsa
Hendren, Walter Scott, Jr. ....216 S.W. 24, Okla. City
Henke, J. R. ....Hydro
Henley, Billie Gene (AP) ....Shawnee
Henley, Marvin D. ....Med. Arts Bldg., Tulsa
Henry, Eugene M. ....204 N. 3, Muskogee
Henry, Gifford H. ....Court Arcade Bldg., Tulsa
Henry, M. L. ....McAlester
Henton, R. H. (AP) ....Sand Springs
Herlihy, Robert M. ....Broadway Tower, Enid
Herold, Philip F. ....El Reno
Herrmann, Jess D. ....525 N.W. 11, Okla. City
Hetherington, L. P. ....Miami
Hicks, C. A. ....Holdenville
Hicks, Fred B. ....Med. Arts Bldg., Okla. City
Hicks, J. T., Jr. (AP) ....Lawton
Hicks, Melvin C. (M) ....Military Address Unknown
Highland, J. E. ....Miami
Hill, C. B. (L) ....Guthrie
Hill, O. L. ....915 S. Cin., Tulsa
Hindman, W. M. ....Detroit, Michigan
Hines, S. J. T. (L) ....Tahlequah
Hinshaw, J. R. ....Norman
Hinson, Bruce R. ....330 S. 5, Enid
Hinton, Robert (J) ....1653 E. Tulsa

Hirshfield, A. C. ....Med. Arts Bldg., Okla. City
Hirst, Claude M. ....Shawnee
Hobbs, A. F. (L) (F) ....Hinton
Hodgson, C. M. ....Kingfisher
Hogaboom, G. M. ....Heavener
Hohl, James F. ....Watertown, Mass.
Hoke, Clarence C. ....Philtower Bldg., Tulsa
Hoke, Lillian ....Hugo
Holcomb, Mark D. ....Broadway Tower, Enid
Holcombe, R. N. ....Surety Bldg., Muskogee
Holland, C. K. ....McAlester
Hollingsworth, Francis W. ....5313 N. Dewey, Okla. City
Hollis, J. B. ....Mangum
Hollis, J. E. ....Bristow
Hollis, Lynn E. ....Tinker Field, Okla. City
Holman, James H. (AP) ....Tipton
Holt, Robert P. (M) ....Lackland A.F.B., San Antonio, Texas
Holt, Willard D. ....Altus
Hood, F. Redding ....1220 N. Walker, Okla. City
Hood, James O. (M) ....Norman
Hooper, J. S. (H) ....Rt. No. 2, Rome, New York
Hoover, Wilkie D. ....Stanolind Bldg., Tulsa
Hopkins, Glenn A. ....Guymon
Hopkins, P. W. ....Broadway Tower, Enid
Hopps, Howard C. ....801 N.E. 13, Okla. City
Horn, John E. ....1620 W. Okmulgee, Muskogee
Horne, Malcom ....Ardmore
Hotz, Carl J. ....604 S. Cin., Tulsa
Hough, Jack Van Doren ....301 N.W. 12, Okla. City
Howard, Herbert H. ....605 Gore Blvd., Lawton
Howard, Robert B. ....1200 N. Walker, Okla. City
Howard, R. M. (L) (F) ....815 N.W. 15, Okla. City
Howard, Robert P. ....825 N.E. 13, Okla. City
Howard, Thomas D. ....Idabel
Howard, W. A. ....Chelsea
Howe, J. Holland ....Ponca City
Howell, O. E. (H) ....Norman
Hoyt, Arthur W. ....Chickasha
Hubbard, John R. ....1501 N.E. 11, Okla. City
Hubbard, Ralph W. ....1501 N.E. 11, Okla. City
Hubbard, William E. ....1501 N.E. 11, Okla. City
Huber, Walter A. ....Med. Arts Bldg., Tulsa
Huckaby, B. M. ....Antlers
Hudson, David V. ....521 N. Boulder, Tulsa
Hudson, Fred A. ....610 S. Monroe, Enid
Hudson, Harry H. ....610 S. Monroe, Enid
Hudson, L. D. ....Dewey
Hudson, Margaret G. ....1759 S. Victor, Tulsa
Huff, Dick H. ....711 N.W. 10, Okla. City
Huff, Thomas J., Jr. ....1220 N. Walker, Okla. City
Huggins, J. R. ....Med. Arts Bldg., Okla. City
Hughes, Horton E. ....Shawnee
Humphrey, B. H. ....Sperry
Humphrey, D. W. ....Cushing
Huntington, Camp S. ....Bartlesville
Husband, Wm. G. (AP) ....Elk City
Huston, H. E. (L) ....Kiowa, Kansas
Hyatt, E. G. ....604 S. Cin., Tulsa
Hyde, W. A. ....Durant
Hyer, J. V. ....Garber
Hyroop, Gilbert L. ....1220 N. Walker, Okla. City
Hyroop, Muriel ....1133 N.W. 40, Okla. City

—I—

Ihrig, H. K. ....1701 E. 19, Tulsa
Ingle, John D. ....1200 N. Walker, Okla. City
Irby, J. P. ....Altus
Ishmael, William K. ....605 N.W. 10, Okla. City
Ivy, W. S. ....Duncan

—J—

Jackson, A. R. ....2519½ S. Robinson, Okla. City
Jacob, John B. ....Waurika
Jacobs, Minard F. ....Med. Arts Bldg., Okla. City
Jacobs, Raymond G. ....310 S. 5th, Enid
Jacobs, William S. ....Court Arcade Bldg., Tulsa
Jacoby, J. S. ....Commerce
Jenkins, W. P. ....Okemah
Jesse, Claron H. ....Ardmore
Jeter, Hugh ....1200 N. Walker, Okla. City
Jobe, James P. (AP) ....El Reno
Jobe, Virgil R. ....1213 N. Hudson, Okla. City
Johnson, A. L. ....El Reno
Johnson, C. L., Jr. ....Bartlesville
Johnson, E. A. ....Hugo
Johnson, E. O. ....Med. Arts Bldg., Tulsa
Johnson, G. E. ....Ardmore
Johnson, H. L. ....Ft. Supply
Johnson, Maxwell ....Med. Arts Bldg., Tulsa
Johnson, Newman (J) ....1653 E. 12, Tulsa
Johnson, Porteous ....Surety Bldg., Muskogee
Johnson, Robert Hall ....2020 S. Xanthus, Tulsa
Johnson, R. Chadwick (J) ....Sand Springs
Johnson, R. Ray (M) ....Grants Pass, Oregon
Johnson, R. R. (L) ....Sand Springs
Johnson, S. E. ....Commercial Natl., Bldg., Muskogee
Johnson, Walter (L) ....Ardmore
Johnston, L. A. S. ....Holdenville
Jones, Amy (J) ....1653 E. 12, Tulsa
Jones, Craig S. ....915 S. Cin., Tulsa
Jones, Delmas B. ....Norton, Va.
Jones, Edward A. (M) ....Newport, R. I.
Jones, Hugh ....Med. Arts Bldg., Okla. City
Jones, John Paul (H) (F) ....Dill
Jones, Phyllis E. ....Med. Arts Bldg., Okla. City
Jones, Ralph E. ....Nicoma Park
Jones, W. E., Sr. ....Seminole
Jones, W. E., Jr. ....Seminole
Joseph, Philip G. ....Sapulpa
Joyce, Charles W. ....Fletcher
Judd, Loyd (AP) ....Pawnee

—K—

Kaeiser, W. H. (M) ....Ft. Benning, Ga.
Kahn, Robert W. ....Med. Arts Bldg., Okla. City
Kaiser, George L. ....Manhattan Bldg., Muskogee
Kalmon, Edmond H., Jr. ....301 N.W. 12, Okla. City
Karasek, Matthew ....Shidler
Karlick, Joseph R. ....Ardmore
Kayler, R. C. (F) ....McLoud
Kell, Thornton ....Ardmore
Keen, Frank M. ....Shawnee
Keller, W. Floyd ....Med. Arts Bldg., Okla. City
Kelley, James W. ....Philtower Bldg., Tulsa
Kelso, Joseph W. ....525 N.W. 11, Okla. City
Keltz, Bert F. ....1111 N. Lee, Okla. City
Kemmerly, H. P. ....Med. Arts Bldg., Tulsa
Kennedy, Julian J. (M) ....Ft. Sam Houston, Texas
Kerekes, Ernest S. ....1923 S. Utica, Tulsa
Kerley, W. W. (H) ....Anadarko
Kernek, Clyde ....Holdenville
Kernek, Paul ....Holdenville
Kernodle, Stratton E. ....First Natl. Bank Bldg., Okla. City
Kerr, Walter C. H. ....Picher
Ketcham, Hall (A.P.) ....Medical Arts Bldg., Tulsa
Kilpatrick, E. S. ....Elk City
Kilpatrick, G. A. ....Henryetta
Kimball, George H. ....1111 N. Lee, Okla. City
Kimerer, Neil B. ....800 N.E. 13, Okla. City
King, E. W. ....Bristow
King, Everett G. (M) ....867 Arlington Ave., Berkeley, California
Kingman, W. H. (H) ....Bartlesville
Kinsinger, R. R. ....Blackwell
Kirby, L. R. ....Cherokee
Kishner, Leonard L. ....1619 E. 15, Tulsa
Klass, O. C. ....Surety Bldg., Muskogee
Knight, Arthur L. (J) ....605 N.W. 10, Okla. City
Knight, Claude B. ....Wewoka
Kolb, I. N. ....Blanchard
Kornblee, A. T. ....Med. Arts Bldg., Tulsa
Kouri, Phillip (M) ....Hospital Group, A.P.O, 54, c/o P. M., San Francisco, Cal.
Kramer, Allen C. ....Med. Arts Bldg., Tulsa
Kreger, Glen S. ....Tonkawa
Kreger, J. Russell ....Tonkawa
Krieger, Carl, Jr. ....1220 N. Walker, Okla. City
Kuhn, John F. ....1111 N. Lee, Okla. City

Kupka, John F. .....Haskell
Kuyrkendall, L. C. .....McAlester

—L—

Lachman, Ernest .....801 N.E. 13, Okla. City
LaFon, W. F. .....Alva
Lain, E. S. (H) (F) .....Med. Arts Bldg., Okla. City
Lam, W. B. .....Clinton
Lamb, Ellis .....Clinton
Lamb, John H. .....Med. Arts Bldg., Okla. City
Lambert, J. B. .....Lexington
Lambke, Phil M. .....105 N.W. 23, Okla. City
LaMotte, George A. (H) (F) Colcord Bldg., Okla. City
Lane, Marie Thaxton .....9407 N. Francis, Okla. City
Lane, Wilson H. .....9407 N. Fraucis, Okla. City
Lang, S. A. .....Nowata
Langston, Wann .....525 N.W. 11, Okla. City
Lansden, J. B. (L) (F) .....Granite
Larkin, H. W. (L) .....Guthrie
Larrabee, Walter S. .....Med. Arts Bldg., Tulsa
Lattimore, Frank C. .....Kingfisher
Laurens, Henry, Jr. .....Ada
Lawrence, Forrest C. .....Bartlesville
Lawton, Pat .....Marietta
Lawson, Robert C. .....301 N.W. 12, Okla. City
Lawton, W. P. .....El Reno
Layton, O. E. .....Collinsville
Leachman, T. C. (L) (F) .....Richmond, Va.
LeBlanc, William (L) (F) .....Ochelata
Ledbetter, Marion K. .....1453 S. Quaker, Tulsa
Lee, Judak K. .....Court Arcade Bldg., Tulsa
Lee, Otis S. .....Springer Clinic, Tulsa
Leebron, William M. .....Elk City
LeHew, Elton W. .....Guthrie
LeHew, J. L., Jr. .....Guthrie
LeHew, J. L., Sr. (L) (F) .....Pawnee
Lehman, Donald S. .....Elk City
Lehmer, Elizabeth E. .....Vinita
Leibovitz, Martin .....Med. Arts Bldg., Tulsa
LeMaster, D. W. (L) .....Wayne
Lembke, Robert L. .....Pryor
Lemon, Cecil W. .....1200 N. Walker, Okla. City
Leney, Fannie Lou .....525 N.W. 11, Okla. City
Leonard, Charles E. .....525 N.W. 11, Okla. City
Lerblanc, William P., Jr. .....Hartshorne
Leslie, S. B., Sr., (L) (F) .....Okmulgee
Leslie, S. B., Jr. .....Okmulgee
Lester, Eugene F., Jr. .....515 N.W. 11, Okla. City
Letcher, C. W. .....Miami
Levy, Bertha M. .....1200 N. Walker, Okla. City
Lewis, Ceylon S. .....Med. Arts Bldg., Tulsa
Lewis, P. K. .....Sapulpa
Lewis, R. W. .....Sulphur
Lewis, Wilburt F. .....605 Gore Blvd., Lawton
Lhevine, Dave B. .....Med. Arts Bldg., Tulsa
Lhevine, Morris B. .....Med. Arts Bldg., Tulsa
Lindley, E. C. .....Duncan
Lindley, E. H. .....Duncan
Lindsay, Joseph H. (AP) .....Dewey
Lindsay, Ray H. .....Pauls Valley
Lindstrom, W. Carl .....Med. Arts Bldg., Tulsa
Lingenfelter, Forrest M. .....1200 N. Walker, Okla. City
Lingenfelter, Paul B. .....Clinton
Lipnick, Louis .....V. A. Regional Office, Muskogee
Lisle, A. C., Jr., ...1200 N. Walker, Okla. City
Little, A. C. .....Minco
Little, J. R. .....3626 N. Western, Okla. City
Lively, C. E. .....McAlester
Livingston, L. G. .....Cordell
Loney, W. R. R. .....Med. Arts Bldg., Tulsa
Loescher, Thomas M. .....Sapulpa
Lockard, Vern (A.P.) .....Bartlesville
Long, LeRoy D. .....Med. Arts Bldg., Okla. City
Long, Loyd L., Jr. .....Ardmore
Loucks, James E. (A.P.) .....1111 N. Lee, Okla. City
Loudon, James D. .....Shawnee
Loughmiller, Robert F. .....Med. Arts Bldg., Okla. City
Love, R. S. (L) .....2701 N.W. 19, Okla. City
Lowbeer, Leo .....1653 E. 12, Tulsa
Lowe, J. O. .....Thompson Bldg., Tulsa
Lowe, Robert C. .....800 N.E. 13, Okla. City
Lowenstein, Bernard (A) .....Sonora, New Mexico
Lowrey, Robert W. .....Poteau
Lowry, David .....521 N.W. 11, Okla. City
Lowry, Dick, Jr. .....1200 N. Walker, Okla. City
Loy, C. F. .....521 N.W. 11, Okla. City
Loy, Richard W. .....Pawhuska
Loy, Robert L. Jr. (M) c/o Postmaster, San Francisco, California
Loy, William A. .....Pawhuska
Loyd, E. M. (H) .....Harlingen, Texas
Lubin, Emanuel N. .....Med. Arts Bldg., Tulsa
Lucas, A. C. (H) (F) .....Castle
Lucas, Boyd Vance .....2641 S. Columbia, Tulsa
Lusk, Earl M. .....915 S. Cin., Tulsa
Luton, James P. .....Med. Arts Bldg., Okla. City
Lynch, Russell H. .....Hollis
Lynch, Thomas J. (L) .....2132 E. 24, Tulsa
Lyon, J. I. (H) (F) .....Edmond
Lyons, Mason R. .....Turley
Lysaught, J. Neill .....301 N.W. 12, Okla. City

—M—

Maben, Charles S. .....Okmulgee
Mabry, Earl W. .....Altus
Mabry, W. L. (L) .....Leedey
MacDonald, Daniel M. .....1531 E. 15, Tulsa
MacDonald, J. C. .....301 N.W. 12, Okla. City
MacKenzie, Ian .....Med. Arts Bldg., Tulsa
MacKercher, Peter A. .....Ponca City
Macrory, Paul D. .....108½ S. College, Bethany
Macumber, H. H. .....Chickasha
Mahone, M. Wilson .....Hobart
Mall, W. W. .....Ponca City
Maloney, V. J. Jr. .....300½ W. Main, Ardmore
Manning, Wesley .....Pawhuska
Margo, Elias .....605 N.W. 10, Okla. City
Margoline, Berthe .....2739 E. 22, Tulsa
Marll, Joseph J. .....Med. Arts Bldg., Okla. City
Marll, William D. .....807 N.W. 23, Okla. City
Markland, James D. .....Med. Arts Bldg., Tulsa
Marks, W. R. .....Vinita
Martin, Chelsey M. .....Elgin
Martin, E. O. .....Cushing
Martin, Frank J. .....Ada
Martin, James D. .....Cushing
Martin, John W. .....Cushing
Martin, J. T. (L) .....3110 Harvey Parkway, Okla. City
Martin, Louis A. .....Sapulpa
Martin, Ralph F. .....Sand Springs
Mason, Rebecca H. .....Chickasha
Masters, H. A. .....Tahlequah
Masterson, Maude M. .....1200 N. Walker, Okla. City
Matheney, J. C. (L) .....Okmulgee
Mathews, Charles R., 63 Broad St., Rochester, New York
Mathews, Dewey .....Tonkawa
Mathews, Grady F. .....State Health Dept., Okla. City
Matt, John G. .....Med. Arts Bldg., Tulsa
Matthews, N. Sanford .....1319 Classen Drive, Okla. City
Matthews, Virgil D. .....Surety Bldg., Muskogee
Matthey, William A. .....1904 Ferris Ave., Lawton
Mayes, R. H. .....Anadarko
Mayfield, W. T. .....Norman
Mayginnes, P. H. (H) (F) .....1624 N. Norfolk, Tulsa
Mays, W. G. (J) .....1923 S. Utica, Tulsa
Mazzarella, Vincent .....Hominy
McAlister, L. S. .....Barnes Bldg., Muskogee
McAllister, D. W. .....Bristow
McBrayer, W. H. (L) .....Idabel
McBride, Earl D. .....605 N.W. 10, Okla. City
McBride, Ollie .....Ada
McCalib, D. C. (L) .....Colbert
McCarley, T. H. .....McAlester
McCauley, D. W. .....Okmulgee
McClure, Coye W. .....Med. Arts Bldg., Okla. City
McClure, H. M. .....Chickasha
McClure, P. L. (H) .....Ft. Cobb
McClure, W. C. .....1200 N. Walker, Okla. City
McCollum, W. T. .....415 N.W. 12, Okla. City
McConnell, L. H. (L) (F) .....Altus

McCreight, William G. .....525 N.W. 11, Okla. City
McCroskie, M. R. .....Fairview
McCurdy, W. C., Jr. .....Purcell
McDaniel, Samuel J. .....26 S.W. 25, Okla. City
McDonald, Glen W. .....Pawhuska
McDonald, John E. .....Tri-State Ins. Bldg., Tulsa
McDonald, Justin J. .....Coffeyville, Kansas
McDougal, Burton B. .....Chickasha
McDowell, Richard Earl .....222½ E. 5, Tulsa
McDowell, Thomas A. (A.P.) Medical Arts Bldg., Tulsa
McElroy, Thomas .....Ponca City
McFarling, Alonza C. .....Shawnee
McGee, J. P. .....1200 N. Walker, Okla. City
McGill, Ralph A. .....Med. Arts Bldg., Tulsa
McGolrick, J. B. (M) .....A.P.O. 25, c/o P.M., San Francisco
McGovern, J. D. .....Wewoka
McGrath, Thomas J. .....Sayre
McGraw, W. L. .....1330 S. Lewis, Tulsa
McGrew, Edwin A. .....Beaver
McGrew, E. A. .....Beaver
McHenry, L. Chester .....Med. Arts Bldg., Okla. City
McInnis, Dalton (M) .....Military Address Unknowu
McInnis, James T. .....2912 S. Walker, Okla. City
McIntosh, R. K., Jr. .....Tahlequah
McIntyre, John A. .....Broadway Tower, Enid
McIntyre, Ray V. (AP) .....Kingfisher
McKee, Robert .....522 N.W. 13, Okla. City
McKeel, Sam A. (H) (F) .....Ada
McKinney, G. Y. .....Henryetta
McKinney, Milam F. .....Med. Arts Bldg., Okla. City
McLauchlin, James R., Jr. .....521 N.W. 11, Okla. City
McLauchlin, Robert A. (M) .....Montgomery, Alabama
McMillan, C. B. .....Gracemont
McMillan, J. M. .....Vinita
McNaughton, G. P. .....Miami
McNeal, Don (M) .....Greenville, Miss.
McNeill, Philip M. .....Med. Arts Bldg., Okla. City
McVey, G. M. (L) .....Verden
Meaus, Royce B. (M) .....Ft. Sill, Okla.
Mechling, George S. .....2217 N.W. 27, Okla. City
Medearis, P. H. .....Tahlequah
Meiers, R. L. (M) .....V.A. Hospital, Topeka, Kansas
Melinder, Roy J. .....Claremore
Melton, A. S. .....Okemah
Mercer, Wendall J. .....First Natl. Bauk Bldg., Enid
Merrell, Webber W. .....Guthrie
Merrifield, F. R. .....Mooreland
Merrifield, Vernou C. .....Ponca City
Merritt, Iva S. .....Norman
Mery, Albert M. .....Braniff Bldg., Tulsa
Messenbaugh, J. F. .....1111 N. Lee, Okla. City
Messinger, R. P. .....807 N.W. 23, Okla. City
Mileham, Jack C. .....Chandler
Miles, John B. .....Anadarko
Miles, W. H. .....Municipal Bldg., Okla. City
Miller, D. Evelyn (AP) .....Honor Heights Dr., Muskogee
Miller, Elnora G. .....McBirney Bldg., Tulsa
Miller, George H. .....Atlas Life Bldg., Tulsa
Miller, Nesbitt L. .....Med. Arts Bldg., Okla. City
Miller, O. H. .....400 N.W. 13, Okla. City
Miller, Oscar H. .....Ada
Miller, W. C. .....Guthrie
Milligan, E. F. .....Geary
Mills, R. C. .....Hightower Bldg., Okla. City
Ming, C. M. .....Okmulgee
Minor, R. W. .....Spiro
Minor, S. W. (L) .....Hinton
Mishler, Donald L. .....604 S. Cin., Tulsa
Mitchell, Clarence .....Norman
Mitchell, Joseph N. .....Koehler Bldg., Lawton
Mitchell, Tom Hall .....Natl. Bank of Tulsa Bldg., Tulsa
Mitchener, W. C. (L) (F) .....Okmulgee
Mogab, John H. .....El Reno
Mohler, E. C. .....Ponca City
Mohrmau, Silas S. (L) .....1818 E. 15, Tulsa
Mollison, Malcolm .....Altus
Monfort, Mariam F. (AP) .....Alva
Monroe, Hugh H. .....Pauls Valley
Moor, Hiram D. (AP) .....1409 N. Portland, Okla. City
Moore, C. D. .....Cravens Bldg., Okla. City
Moore, Clifford W. .....Stillwater
Moore, Charles F. .....Durant
Moore, Edward L. .....Braniff Bldg., Tulsa
Moore, Ellis .....Med. Arts Bldg., Okla. City
Moore, Matthew B. .....Braniff Bldg., Tulsa
Moore, Samuel T. .....515½ N.W. 11, Okla. City
Moorman, Floyd .....1220 N. Walker, Okla. City
Moorman, Lewis J. (F) .....1200 N. Walker, Okla. City
Morey, John B. .....Ada
Morgan, C. A. .....Home State Life Bldg., Okla. City
Morgan, Carl C. .....1701 E. 19, Tulsa
Morgan, James E. .....Guymon
Morgan, R. J. .....1111 N. Lee, Okla. City
Morgan, Vance F. .....Harrah
Morledge, Walker .....1220 N. Walker, Okla. City
Morrison, H. C. .....807 N.W. 23, Okla. City
Morrison, J. W. .....1200 N. Walker, Okla. City
Morrow, B. L. .....Salina
Morrow, John A. (H) (F) .....Sallisaw
Morton, R. W. .....Sulphur
Mosher, D. D. .....Seminole
Mosely, Kirk T. .....Norman
Mote, Paul .....Sapulpa
Mote, W. R. .....Ardmore
Moth, M. V. (L) .....2001 N. Lottie, Okla. City
Moxley, Joe N. .....Ardmore
Mulmed, Earl I. .....Braniff Bldg., Tulsa
Mulvey, Bert E. .....1111 N. Lee, Okla. City
Munding, L. A. .....Med. Arts Bldg., Tulsa
Muntz, Earl R. .....Ada
Murdock, H. D. .....Med. Arts Bldg., Tulsa
Murdock, Raymond L. .....Med. Arts Bldg., Okla. City
Murray, Ella H. .....905 N.W. 95, Okla. City
Murray, Silas (L) .....Med. Arts Bldg., Tulsa
Musick, E. R. .....Med. Arts Bldg., Okla. City
Mussil, W. M. .....Med. Arts Bldg., Okla. City
Myers, David A. (H) .....1250 Jines St., San Francisco, Cal.
Myers, Jack W. .....El Reno

—N—

Nagle, Patrick S. .....1021 N. Lee, Okla. City
Nathan, Robert E. .....Med. Arts Bldg., Tulsa
Navin, Kenneth W. .....Shawnee
Neal, James H. .....521 N. Boulder, Tulsa
Neal, James H., Jr. .....915 S. Cin., Tulsa
Neal, L. G. .....Ponca City
Needham, C. F. .....Ada
Neel, Roy L. (J) .....950 E. 59, Chicago, Ill.
Neely, Shade D. .....Commercial Natl. Bank, Muskogee
Neff, Everett B. .....1200 N. Walker, Okla. City
Neilson, William P. .....Broadway Tower, Enid
Nelson, F. L. .....2303 East 3rd, Tulsa
Nelson, Frank J. .....2020 S. Xanthus, Tulsa
Nelson, Harold G. .....Stillwater
Nelson, Iron H. .....Med. Arts Bldg., Tulsa
Nelson, M. O. .....Med. Arts Bldg., Tulsa
Nesbitt, P. P. (H) .....1565 Swau Drive, Tulsa
Neumann, Milton A. .....Okarche
Newell, W. B., Jr. .....230 S. 5th, Enid
Newell, W. B., Sr. .....Brodawy Tower, Enid
Newlin, Frances P. .....Shawnee
Newlin, W. H. .....Broken Arrow
Newman, Floyd .....Shattuck
Newman, M. H. .....Shattuck
Newman, O. C. (F) .....Shattuck
Newman, Roy E. .....Shattuck
Nichol, Byron A. (A) Station Hospital, Ft. Sill, Okla.
Nicholas, Hugh B. .....1918 N. Oxford, Tulsa
Nicholson, Ben H. .....301 N.W. 12, Okla. City
Nicholson, James L. .....Norman
Nielsen, Gertrude .....Norman
Niemann, George H. .....Ponca City
Noell, Robert L. .....1111 N. Lee, Okla. City
Norman, S. L. .....McAlester
Norrick, John H. (H) .....200 N.W. 18, Okla. City
Northcutt, C. E. .....Ponca City
Northrip, Ray U. .....Ada

Northrup, L. C. .....1307 S. Main, Tulsa
Nuckols, A. S. .....Ponca City

—O—

Oakes, Charles G. .....Sapulpa
Obermaun, Charles F. .....Dept. of Mental Hygiene, Capitol Bldg., Okla. City
Obermiller, R. G. .....Woodward
Obert, Paul M. (J) ....3931 Springlake Drive, Okla. City
O'Donoghue, D. H. .....1111 N. Lee, Okla. City
Ogg, Kenneth G. (AP) .....2420 Classen, Okla. City
Oglesbee, Carson L. .....Manhattan Bldg., Muskogee
Ohl, Charles W. .....Chickasha
Oldham, I. B. .....426 N. 6th, Muskogee
O'Leary, Charles M. .....Med. Arts Bldg., Okla. City
O'Leary, D. W. (L) .....Norman
Olson, Donald H. .....Vinita
O'Meilia, W. J. .....Braniff Bldg., Tulsa
Opper, Marshall .....905 S.W. 29, Okla. City
Orr, Herbert S. .....1645 E. 15, Tulsa
Osborn, Carl D. .....Ada
Ottis, Paul J. .....Okarche
Owen, H. Leo .....800 N.E. 13, Okla. City
Oxley, W. N. .....Texhoma

—P—

Padberg, E. D. .....Ada
Palik, Emil E. .....1923 S. Utica, Tulsa
Paramore, Charles F. .....Shawnee
Park, Felix R. .....Med. Arts Bldg., Tulsa
Park, J. F. .....McAlester
Parker, James W. .....Elk City
Parker, Joe M. .....Med. Arts Bldg., Okla. City
Parmenter, D. C. .....1204 S. Cheyenne, Tulsa
Parmley, Van S. .....Maugum
Parrish, John M., Jr. .....522 N.W. 13, Okla. City
Parrish, Pamela P. .....4405 Terry, Okla City
Parrish, R. Gibson .....528 N.W. 12, Okla. City
Parsons, O. L. .....511 "E" Ave., Lawton
Paschal, William R. (AP) ....Med. Arts Bldg., Okla. City
Pascucci, Lucien .....1923 S. Utica, Tulsa
Patterson, F. L. .....Duncan
Patterson, Fred L., Jr. .....Duncan
Patterson, James L., Jr. ....(M) c/o San Francisco, Cal.
Patterson, James L. .....Duncan
Patzer, Reynold .....217 N.W. 13, Okla. City
Paulus, D. D. .....301 N.W. 12, Okla. City
Pavy, C. A. .....Med. Arts Bldg., Tulsa
Payne, Ralph E. .....Edmond
Payne, Richard W. .....521 N.W. 11, Okla. City
Payte, J. I. .....2429 Aurora Court, Okla. City
Peacher, Kenneth L. .....Waynoka
Peden, James C. .....Med. Arts Bldg., Tulsa
Pendleton, Jno. W. .....Kingfisher
Penick, Grider ..... Colcord Bldg., Okla. City
Perry, Daniel (L) .....222 E. 5, Tulsa
Perry, Fred J. .....Braniff Bldg., Tulsa
Perry, Fred T. .....Watonga
Perry, Hugh .....222 E. 5, Tulsa
Perry, John C. .....Med. Arts Bldg., Tulsa
Perry, John M., Jr. .....515 N.W. 11, Okla. City
Peter, M. L. .....Okmulgee
Peters, James C. .....915 S. Cin., Tulsa
Peterson, William G. .....Ada
Petty, C. S. (L) (F) .....Guthrie
Petty, James S. .....Guthrie
Phelan, Ralph S. .....Hobart
Phelps, Joseph T. .....El Reno
Phelps, Malcom E. .....El Reno
Phipps, John .....Vets. Adm. Hospital, Little Rock, Ark.
Pickard, John C. .....1111 N. Lee, Okla. City
Pierson, Dwight, D. .....Maugum
Pierson, O. A. .....Woodward
Pigford, R. C. (L) .....2427 E. 26th, Tulsa
Pittman, Cole D. .....Bartlesville
Poer, E. M. (L) (F) .....Maugum
Points, Thomas C. .....609 N.W. 10th, Okla. City
Pollock, Ira O. .....1200 N. Walker, Okla. City
Pollock, John R. Jr. .....Ardmore
Pollack, Simon .....Braniff Bldg., Tulsa
Poole, Warren .....2025 N.W. 12, Okla. City
Porter, Horace H. .....1419 E. 15, Tulsa
Postelle, Joseph M. (H) (F) .....611 W. Mulberry, San Antonio, Texas
Pounders, Carroll M. .....1220 N. Walker, Okla. City
Powell, Paul T. .....Ponca City
Pratt, T. W. .....Muskogee
Pratt, William C. .....604 S. Cin., Tulsa
Prentiss, H. M. .....Nowata
Presson, L. C. (L) .....1948 N. Main, Tulsa
Price, J. T. .....Seminole
Price, Joel S. .....1200 N. Walker, Okla. City
Prosser, Moorman P. .....Med. Arts Bldg., Okla. City
Pryor, V. W. .....Holdenville
Puckett, Carl .....Box 1661, Okla. City
Puckett, H. L. .....Stillwater

—R—

Raff, Joseph S. .....Madill
Rafter, John R. (J) .....Mission, Kansas
Ragan, T. A. .....Norman
Rainer, Jeanne Shofstall .....1111 N. Lee, Okla. City
Rahhal, George M. .....Atoka
Ralston, B. W. (L) (F) .....Commerce
Ramsay, David C. .....Ada
Ray, Cody .....Pawhuska
Ray, R. G. .....3015 E. 15, Tulsa
Records, John W. .....301 N.W. 12, Okla. City
Reding, A. C. .....Stillwater
Redmond, Robert F. (M) .....Randolph Field, San Antonio, Texas
Redus, Lonnie C. .....Weatherford
Reed, Horace (H) (F) .....1200 N. Walker, Okla. City
Reed, James R. .....Med. Arts Bldg., Okla. City
Reese, C. B. (L) .....Sapulpa
Reese, K. C. .....Med. Arts Bldg., Tulsa
Reeves, C. L. .....1111 N. Lee, Okla. City
Reichert, R. J. .....Norman
Reichmann, Ruth S. .....124 N.W. 15, Okla. City
Reid, John R. .....2420 Classen Blvd., Okla. City
Reid, Roger (M) .....Ardmore
Reifenstein, Edward C., Jr. .....825 N.E. 13, Okla. City
Reiff, William H. .....400 N.W. 13, Okla. City
Rempel, Paul H. .....Broadway Tower, Enid
Renegar, J. F. (L) .....Tuttle
Renfrow, T. F. (H) .....Billings
Renfrow, William B. .....528 N.W. 12, Okla. City
Rentfrow, James W. .....Clinton
Revere, Seth D. .....Chickasha
Rewerts, F. C. .....Bartlesville
Reynolds, Charles L. .....Weleetka
Reynolds, Ernest W. .....1307 S. Main, Tulsa
Reynolds, John H. ....First Natl. Bank Bldg., Muskogee
Reynolds, James L. (H) .....1516 N. Cin., Tulsa
Reynolds, Jack .....Barnes Bldg., Muskogee
Reynolds, S. W. .....Drumright
Rhea, Thomas E. .....Idabel
Rhodes, R. E. L. (L) .....2220 S. St. Louis, Tulsa
Rhodes, William H. (L) .....1714 W. Okla., Enid
Rice, E. Eugene .....Shawnee
Rice, O. W. (L) (F) .....McAlester
Rice, Paul B. .....216 S.W. 24, Okla. City
Richardson, D. P. (H) (F) .....Union City
Richardson, Jack L. .....19 W. 10, Tulsa
Richey, S. M. (H) .....Address Unknown
Ricks, James R. .....Med. Arts Bldg., Okla. City
Riddle, H. K. .....Coweta
Ridgeway, Elmer, Jr. .....2750 N.W. 23, Okla. City
Riley, Lea A. (H) (F) .....Rt. No. 1, Brooks Road, New Canaan, Conn.
Rigual, Rafael .....Wister
Riley, James T. .....El Reno
Riley, Nolan C. .....608 S. Cinn., Tulsa
Ringrose, R. F. .....Guthrie
Rippy, O. M. .....Stillwater
Rissner, A. S. .....Blackwell
Ritter, N. R. .....Picher
Ritzhaupt, Louis H. .....Guthrie
Rix, Alvin, Jr. .....525 N.W. 11, Okla. City
Robberson, Marvin E., Sr. (L) .....Wwnnewood

Robberson, Morton E., Jr. ....Wynnewood
Robert, Robert C. ....Norman
Roberts, Charles J. ....610 S. Monroe, Enid
Roberts, D. D. (L) ....1631 E. Bdwy., Enid
Roberts, R. E. ....Stillwater
Roberts, S. P. (L) ....Nowata
Roberts, T. R. ....Wright Bldg., Tulsa
Robertson, C. W. ....Chandler
Robertson, Edwin N., Jr. ....301 N.W. 12, Okla. City
Robinson, Earl M. ....First Natl. Bank Bldg., Enid
Robinson, Earl W. ....610 S. Monroe, Enid
Robinson, F. P. ....Pond Creek
Robinson, J. H. ....301 N.W. 12, Okla. City
Robinson, Lillian H. ....610 S. Monroe, Enid
Roddy, John A. ....1021 N. Lee, Okla. City
Rogers, C. L. ....Watonga
Rogers, Gerald ....1111 N. Lee, Okla. City
Rogers, James W. ....Med. Arts Bldg., Tulsa
Rogers, McLain ....Clinton
Rollins, James H. ....610 S. Monroe, Enid
Rollins, John Gordon (AP) ....Prague
Rome, Albert (AP) ....Ponca City
Rose, Dayton M. (M) ....Vance A.F.B., Enid
Rosier, Harold A. ....Waurika
Ross, George T. ....First Natl. Bank Bldg., Enid
Ross, Hope S. ....First Natl. Bank Bldg., Enid
Ross, S. P. (H) (F) ....1410 Camden Way, Okla. City
Rountree, Charles R. ....525 N.W. 11, Okla. City
Royer, Charles A. ....525 N.W. 11, Okla. City
Royster, R. L. ....Purcell
Rubin, H. J. ....1619 E. 15, Tulsa
Rucks, W. W., Sr. (L) (F) ....301 N.W. 12, Okla. City
Rucks, W. W., Jr. ....301 N.W. 12, Okla. City
Ruhl, N. E. ....1438 N.E. 23, Okla. City
Ruprecht, H. A. ....604 S. Cin., Tulsa
Russell, G. R. ....604 S. Cin., Tulsa
Russell, Richard ....Miami
Russo, Peter E. ....1111 N. Lee, Okla. City
Rutherford, S. C. (L) ....Locust Grove
Rutherford, V. M. ....328 E. Aeronca Drive, Midwest City
Ryan, Henry G. II (M) ....c/o Postmaster, San Francisco, Cal.

—S—

Saddoris, M. L. ....Cleveland
Salamy, Joseph ....2523 E. 11, Tulsa
Salomon, A. L. ....1111N. Lee, Okla. City
Sanders, Harold R. ....Stillwater
Sanders, Harmon U. ....228 E. 32, Kansas City, Mo.
Sanger, Fenton A. ....921 N.W. 23, Okla. City
Sanger, W. B. ....Med. Arts Bldg., Tulsa
Sanger, W. W. ....1111 N. Lee, Okla. City
Sanger, Winnie M. (L) ....921 N.W. 23, Okla. City
Sapper, H. V. L. ....525 N.W. 11, Okla. City
Saviers, Boyd M. (M) ....Cabaness Field, Corpus Christi, Texas
Sawyer, R. E. ....Durant
Schaff, Hartzell V. ....Holdenville
Schmidt, Loraine ....Sapulpa
Scheider, Edward M. ....1101 E. 15th, Tulsa
Schneble, Richard J. ....Ponca City
Schneider, Robert A. (AP) ....800 N.E. 13, Okla. City
Schreck, Philip M. ....Medical Arts Bldg., Tulsa
Scism, Mollie ....Walters
Scott, H. A. ....Commercial Natl. Bank Bldg., Muskogee
Scott, G. W. ....Tishomingo
Seaborn, T. L. (L) ....Ada
Searle, Maurice J. ....Med. Arts Bldg., Tulsa
Seba, Chester R. ....1204 N. Hudson, Okla. City
Seba, W. E. ....Leedey
Sebring, Milton H. ....2515 Classen Blvd., Okla. City
Sellers, Fred W. ....Mangum
Serwer, Milton J. ....1200 N. Walker, Okla. City
Sethney, Walter F. ....2828 E. 15, Tulsa
Sexton, C. E. (H) (F) ....1130 N.E. 10, Okla. City
Shackelford, John W. ....State Health Dept., Okla. City
Shackelford, Paul O. (J) ....General Delivery, Stony Brook, New York
Shadid, Alexander ....Elk City
Shadid, Fred V. ....Elk City
Shaffer, Jerome D. ....1200 N. Walker, Okla. City
Shapiro, David ....1101 E. 15, Tulsa
Shaver, S. R. ....413 N.W. 12, Okla. City
Sheets, Marion E. ....310 S. 5th, Enid
Shelby, Hudson ....Hales Bldg., Okla. City
Shelby, Richard D. ....Chickasha
Shelton, B. Wright ....Miami
Shelton, J. W. (L) (F) ....Los Angeles, California
Shepard, R. M. ....Med. Arts Bldg., Tulsa
Shepard, Robert M., Jr. ....Med. Arts Bldg., Tulsa
Shepard, S. C. ....Med. Arts Bldg., Tulsa
Sheppard, Mary V. S. ....Med. Arts Bldg., Okla. City
Sherwood, R. G. ....Court Arcade Bldg., Tulsa
Shi, Augustin H. (L) (F) ....Stratford
Shields, Herbert B. ....Broadway Tower, Enid
Shipman, W. H. (H) ....Bartlesville
Shipp, J. D. ....Med. Arts Bldg., Tulsa
Shircliff, E. E. ....128 N.W. 14, Okla. City
Shirley, Edward T. ....Wynnewood
Shoemaker, H. A., Ph.D. (A) ....801 N.E. 13, Okla. City
Shorbe, Howard B. ....605 N.W. 10, Okla. City
Short, L. O. ....Frederick
Showman, W. A. ....Med. Arts Bldg., Tulsa
Shriner, Richard F., Jr. (M) ....c/o Postmaster, San Francisco, Calif.
Shryock, Lelan F. ....Broadway Tower, Enid
Shuller, E. H. ....McAlester
Shuller, Thurman ....McAlester
Shuttee, Robert D. ....First Natl. Bank Bldg., Enid
Simon, Bill J. ....Perry
Simon, Floyd ....Clinton
Simon, John F. ....Alva
Simon, Ralph ....Clinton
Simpson, Carl F. ....Med. Arts Bldg., Tulsa
Simpson, J. D. ....Sapulpa
Simpson, N. N. (H) ....Henryetta
Simpson, J. D. (J) ....1923 S. Utica, Tulsa
Sinclair, F. D. ....Med. Arts Bldg., Tulsa
Singleton, Harry F. (AP) ....1200 N. Walker, Okla. City
Sippel, Mary Edna ....1544 E. 15, Tulsa
Sisler, Frank H. ....Bristow
Sisler, Wade H. ....807 S. Elgin, Tulsa
Slagle, Gene W. (M) U.S. Naval Hosp., Memphis, Tenn.
Sledge, Claire B. (J) ....St. Francis Hosp., Peoria, Ill.
Sleeper, Harold G., Jr. ....Rt. No. 4, Box 65, Okla. City
Smith, A. B. ....Stillwater
Smith, Byron F. (AP) ....800 N.E. 13, Okla. City
Smith, C. E. ....Henryetta
Smith, Charles A. ....Norman
Smith, Delbert G. ....1111 N. Lee, Okla. City
Smith, D. O. ....604 S. Cin., Tulsa
Smith, Donald H. ....Fairview
Smith, Francis E. (AP) ....Kingfisher
Smith, Haskell ....Stillwater
Smith, Henry C. ....Walters
Smith, Joseph G. (L) ....Bartlesville
Smith, Joseph J. ....Shattuck
Smith, L. L. ....229 S.W. 29, Okla. City
Smith, Morris ....Guymon
Smith, Ralph A. ....Med. Arts Bldg., Okla. City
Smith, R. O. ....Hominy
Smith, Ruric N. ....Med. Arts Bldg., Tulsa
Smith, Wendell L. ....2431 E. Admiral Blvd., Tulsa
Smith, William O. ....Tri-State Ins. Bldg., Tulsa
Smith, William Howard (M) Military Address Unknown
Snow, J. B. ....625½ N.W. 10, Okla. City
Snow, Otis ....Ft. Supply
Snyder, J. H. ....Med. Arts Bldg., Okla. City
Somerville, O. S. (L) (F) ....Bartlesville
Souter, J. E. ....Guthrie
Sowell, H. K. ....528 N.W. 12, Okla. City
Spann, Joe L. ....Braniff Bldg., Tulsa
Spann, Logan A. ....Braniff Bldg., Tulsa
Spaulding, H. B. ....Ralstin
Speed, H. K. (H) ....Sayre
Spence, Ray E. ....Pauls Valley
Spence, W. P. ....Sayre
Spickard, L. J. ....Okemah
Spitzer, Lawrence L. ....Marlow
Springer, M. P. ....118 E. 6, Tulsa
Srigley, Robert S. ....Hollis
Stacy, John R. ....605 N.W. 10, Okla. City

Stalker, Harry A. (F) ..... Pond Creek
Stallings, T. W. (L) ..... 724 S. Elgin, Tulsa
Stanbro, Gregory E. ..... 1111 N. Lee, Okla. City
Standifer, O. C. ..... Elk City
Stanley, M. V. ..... 1632 E. 15th, Tulsa
Starkey, Wayne A. ..... Altus
Starr, O. W. ..... Drumright
Starry, L. J. ..... 1200 N. Walker, Okla. City
Staver, B. F. ..... Bartlesville
Steel, Marcella R. ..... 604 S. Cin., Tulsa
Steelman, G. M. ..... Haskell
Steen, Carl T. ..... Pauls Valley
Stephens, Edward F. ..... Norman
Stephens, George K. ..... Ada
Stephens, I. F. ..... Alva
Stevenson, James ..... Med. Arts Bldg., Tulsa
Stewart, H. B. ..... 1701 E. 19, Tulsa
Stilwell, Robert J. ..... Amer. Natl. Bank Bldg., Okla. City
Stokes, E. Malcolm (M) ..... 2500 Med. Group, Mitchell A.F.B., New York, N.Y.
Stokes, Lowell L. ..... 1321 S. Main, Tulsa
Stoll, A. A. ..... Clinton
Stoll, Richard G. ..... Chickasha
Stone, S. N., Jr. ..... 525 N.W. 11, Okla. City
Stough, A. R. ..... McAlester
Stough, Daniel F. Jr. ..... Geary
Stout, Hugh A. ..... 413 N.W. 12, Okla. City
Stout, Marvin E. ..... 209 N.W. 13, Okla. City
Stowell, Averill ..... 604 S. Cin., Tulsa
Stowers, Aubrey E. ..... Sentinel
Street, O. J. (H) ..... Gould
Strecker, William E. ..... 1104 N. Lee, Okla. City
Strenge, Henry B. ..... 800 N.E. 13, Okla. City
Strong, C. Riley ..... El Reno
Strong, Paul T. ..... 2020 S. Xanthus, Tulsa
Stuard, C. G. ..... Court Arcade Bldg., Tulsa
Stuart, Frank A. ..... Tri-State Ins. Bldg., Tulsa
Stuart, Leon H. ..... Med. Arts Bldg., Tulsa
Stuart, Royal E. ..... Braniff Bldg., Tulsa
Sturgeon, H. Violet ..... Hennessey
Sturm, Robert T. ..... 1111 N. Lee, Okla. City
Sugarman, Milton J. ..... Elk City
Sugg, Alfred R. ..... Ada
Sullivan, C. B. ..... Carnegie
Sullivan, Elijah S. ..... Med. Arts Bldg., Okla. City
Sullivan, R. C. ..... Ardmore
Summers, C. S. ..... Daniels Bldg., Tulsa
Sundgren, Vincil ..... 604 S. Cin., Tulsa
Sutliff, Edward H. (A) ..... Clinton
Swan, Joseph J. ..... Chickasha
Swanson, K. F. ..... 604 S. Cin., Tulsa

—T—

Tagge, James Frederick ..... First Natl. Bank Bldg., Enid
Tallant, George A. ..... Frederick
Talley, Charles N. ..... Marlow
Talley, E. Evans ..... Broadway Tower, Enid
Taylor, Charles B. ..... 418 N.E. 15, Okla. City
Taylor, Clarence P., Jr. (M) ..... First Marine Div., c/o P. M. San Francisco, Cal.
Taylor, Jim M. ..... 1111 N. Lee, Okla City
Taylor, John R. ..... Kingfisher
Taylor, Lewis Carroll ..... 528 N.W. 12, Okla. City
Taylor, Robert L. ..... 807 N.W. 23rd, Okla. City
Taylor, R. Z. ..... Blair
Taylor, W. M. (L) (F) ..... 925 N.W. 17, Okla. City
Tedrowe, C. W. (F) ..... Woodward
Tefertiller, Charles L. ..... Altus
Templin, O. E. (L) ..... Alva
Terrill, Robert J. ..... 610 S. Monroe, Enid
Terry, Jack T. ..... Ponca City
Thomas, Denton B. ..... Chelsea
Thomas, Harlan ..... Med. Arts Bldg., Tulsa
Thomas, William F., Jr. ..... Braniff Bldg., Tulsa
Thomasson, E. B. ..... Duncan
Thompson, James Barrett ..... Med. Arts Bldg., Tulsa
Thompson, James B. ..... Atoka
Thompson, M. K. (F) ..... Surety Bldg., Muskogee
Thompson, Oliver H. ..... Court Arcade Bldg., Tulsa
Thompson, Wayman J. ..... 1220 N. Walker, Okla. City
Thompson, William Best ..... Med. Arts Bldg., Okla. City
Thorp, Edward M. ..... Cushing
Threlkeld, L. D. ..... 1220 N. Walker, Okla. City
Tisdal, James H. ..... Clinton
Tisdal, W. C. ..... Clinton
Tolbert, J. B. ..... Mountain View
Tolleson, William A. (H) (F) ..... Eufaula
Toma, Paul ..... 2112 N.W. 12, Okla. City
Tompkins, J. E. (L) ..... Yukon
Tompkins, S. Fulton ..... 1111 N. Lee, Okla. City
Tool, C. Donovan ..... Vet. Adm., Will Rogers Field, Okla. City
Torrey, J. P. (L) (F) ..... Bartlesville
Townsend, Cary W. ..... Med. Arts Bldg., Okla. City
Tracewell, George L. ..... Okmulgee
Tracy, Gilbert W. (AP) ..... 1524 W. Okmulgee Ave., Muskogee
Trainor, W. J. ..... Med. Arts Bldg., Tulsa
Traverse, C. A. ..... Alva
Trent, Robert I. ..... 1111 N. Lee, Okla. City
Triplett, T. Burke ..... Mooreland
Trow, T. A. ..... Henryetta
Truman, A. W. ..... 300 W. Main, Ardmore
Tullius, Philip G. ..... 1200 N. Walker, Okla. City
Tulloch, George M. ..... Bartlesville
Turley, Louis A. (A) ..... 801 N.E. 13, Okla. City
Turnbow, W. R. ..... 3015 E. 15, Tulsa
Turnbull, Theodore G. ..... 222 E. 5th, Tulsa
Turner, Henry H. ..... 1200 N. Walker, Okla. City
Turner, R. D. ..... Barnes Bldg., Muskogee
Turner, Thomas R. ..... 604 S. Cin., Tulsa
Tuttle, Howard D. (AP) ..... Wagoner
Tyler, Joe E. ..... 604 S. Cin., Tulsa

—U—

Underwood, David J. ..... Med. Arts Bldg., Tulsa
Underwood, F. L. ..... Med. Arts Bldg., Tulsa
Ungerman, A. H. ..... Med. Arts Bldg., Tulsa
Ungerman, Milford S. ..... Med. Arts Bldg., Tulsa

—V—

Vahlberg, Ernest R. (R) ..... 609 N.W. 42, Okla. City
Vammen, Adolph N. (AP) ..... 1415 E. 15, Tulsa
Vandever, H. F. ..... First Natl. Bank Bldg., Tulsa
Van Matre, R. M. ..... 432 N.W. 22, Okla. City
Vansant, J. P. ..... Dewey
Varian, Thelma S. ..... Wagoner
Veazey, J. H. ..... Little Bldg., Ardmore
Veazey, Lyman C. ..... 420½ Stanley, Ardmore
Venable, Sidney C. (L) ..... 1757 S. Columbia, Tulsa
Vickers, Paul M. ..... 525 N.W. 11, Okla. City
Vieregg, F. R. ..... Clinton
Vloedman, D. A. (AP) ..... Woodward
Von Wedel, Curt ..... 610 N.W. 9, Okla. City

—W—

Wade, Glen F. ..... 1111 N. Lee, Okla. City
Wadsworth, R. M. ..... 1445 S. Quaker, Tulsa
Waggoner, E. E. ..... Tonkawa
Waggoner, R. E. ..... Stillwater
Wagner, J. C. ..... Ponca City
Wails, T. G. ..... Med. Arts Bldg., Okla. City
Wainwright, Tom L. ..... Mangum
Wait, Will C. (L) ..... McAlester
Waldrop, William L. ..... 605 N.W. 10, Okla. City
Walker, Agnew A. ..... Wewoka
Walker, C. F. (F) ..... Grove
Walker, Dean C. ..... 604 S. Cin., Tulsa
Walker, Ethel M. ..... 300½ W. Main, Ardmore
Walker, Ethan A. ..... Yukon
Walker, G. I. ..... Hominy
Walker, I. D. ..... Tonkawa
Walker, J. Robert ..... 528 N.W. 12, Okla. City
Walker, Roscoe ..... Pawhuska
Walker, W. A. ..... 1215 S. Utica, Tulsa
Walker, W. K. ..... Marlow
Wallace, Albert W. ..... 604 S. Cin., Tulsa
Wallace, J. E. (L) ..... 1323 S. Peoria, Tulsa
Waltrip, Jesse R. ..... Pauls Valley
Ward, Benjamin W. ..... 1916 S. Utica, Tulsa
Warterfield, Floyd (H) (F) ..... Commercial Natl. Bldg., Muskogee
Waterbury, C. Ray ..... Apache
Waters, C. B. ..... Pawnee
Waters, Floyd L. ..... Hugo
Watkins, B. H. (L) ..... Hobart
Watson, O. Alton ..... 1200 N. Walker, Okla. City

Weaver, William N. .....Manhattan Bldg., Muskogee
Weber, A. G. .....Goltry
Weber, Fred W. (AP) ....Post Office Bldg., Midwest City
Weber, Roxie .....Stillwater
Weedn, A. J. .....Duncan
Weinberg, Harry B. (AP) .....1001 E. 15th, Tulsa
Welborn, O. E. .....Ada
Welborn, O. M. .....Ada
Wells, Eva .....Med. Arts Bldg., Okla. City
Wells, Lois L. .....1111 N. Lee, Okla. City
Wells, Thomas J. .....Bartlesville
Wendel, William E., Jr. .....Eufaula
Wendelken, H. W. .....Miami
Wengor, Theodore R. (AP) .....Tecumseh
Werling, E. H. .....Pryor
West, Glenn A. .....Duncan
West, Kelly M. (AP) .....1200 N. Walker, Okla. City
West, W. K. .....1200 N. Walker, Okla. City
Westfall, L. M. (L) .....1502 Wilshire Blvd., Okla. City
Wharton, J. L. (L) (F) .....Depew
Wheeler, H. C. .....McAlester
White, Charles Ed .....526 N. 6th, Muskogee
White, Eric M. .....Med. Arts Bldg., Tulsa
White, Harold A. .....Med. Arts Bldg., Tulsa
White, J. H. .....Ardmore
White, J. Hutchings (H) (F) ....Surety Bldg., Muskogee
White, James W. .....1515 S. Boston, Tulsa
White, L. M. (AP) .....614 "C" Ave., Lawton
White, M. S. .....Blackwell
White, N. S. .....Med. Arts Bldg., Tulsa
White, Oscar .....1200 N. Walker, Okla. City
White, Phil E. .....318 N.W. 13, Okla. City
Whitely, Seals L. .....Durant
Whiteneck, Rhonald A. .....Waynoka
Whitney, M. L. .....Okemah
Wicker, Walter, Jr. .....605 Gore Bldg., Lawton
Wickham, M. M. .....Norman
Wight, Avery B. .....Bass Bldg., Enid
Wilbanks, Charles E. .....717 N. Lewis, Tulsa
Wildman, S. F. .....Med. Arts Bldg., Okla. City
Wiley, A. Ray .....Med. Arts Bldg., Tulsa
Wiley, George A. .....1111 N. Lee, Okla. City
Wilhite, L. R. .....Perkins
Wilkins, Harry .....525 N.W. 11, Okla. City
Willard, D. G. .....Norman
Williams, Alpha McAdams .....Shawnee
Williams, Byron E. .....525 N.W. 11, Okla. City
Williams, C. E. .....Woodward
Williams, C. O. (L) .....McAlester
Williams, Claude H. .....Okeene
Williams, Gordon .....Weatherford
Williams, J. Clay .....Durant
Williams, Leonard C. .....1200 N. Walker, Okla. City
Williams, N. K. .....McCurtain
Williams, R. W. (L) .....Evergreen, Colorado
Williams, Theodore S. .....Med. Arts Bldg., Tulsa
Willour, L. S. (H) (F) .....McAlester
Wilner, Sol .....Med. Arts Bldg., Tulsa
Wilson, Charles Hugh .....Med. Arts Bldg., Okla. City
Wilson, Donald J. .....Pauls Valley
Wilson, George S. .....610 S. Monroe, Enid
Wilson, Herbert A. .....McAlester
Winkelman, George W. (M) V. A. Hospital, Will Rogers Field, Okla. City
Winn, George L. .....711 N.W. 10, Okla. City
Witcher, Edward K. .....Vinita
Witcher, Robert B. .....Med. Arts Bldg., Tulsa
Witten, Harold B. (J) .....Gulfport, Miss.
Wolf, Llewellyn, G. (L) .....Okarche
Wolf, Stewart G. (AP) .....800 N.E. 13, Okla. City
Wolfe, Henry D. .....Hugo
Wolfe, I. C. .....426 N. 6th, Muskogee
Wolff, Eugene G. .....1701 E. 19, Tulsa
Wolff, John Powers .....1200 N. Walker, Okla. City
Wolever, Leroy ..... 328 E. Aeronca, Midwest City
Wolohon, Harry C. ....3328 N. Classen Blvd., Okla. City
Wood, Jack A. .....Seminole
Wood, J. Guild .....Weatherford
Wood, James L. .....Eufaula
Wood, Julian D. .....Seminole
Wood, W. M. .....Barnes Bldg., Muskogee
Woodard, C. E. .....Drumright
Woodburn, Joel T. .....Barnes Bldg., Muskogee
Woods, L. E. .....Chickasha
Woodson, E. M. .....Poteau
Woodson, Fred E. .....Med. Arts Bldg., Tulsa
Woodson, O. M. .....Norman
Woodward, Neil W. .....631 N.W. 10, Okla. City
Wooldridge, Bart F. (J) .....2000 Hayes St., Nashville, Tennessee
Word, Lee B. .....Bartlesville
Wormington, F. L. (F) .....Miami
Worobec, Thomas (AP) .....Shawnee
Worten, Divonis .....Pawhuska
Wright, Harper .....318 S.W. 25, Okla. City
Wright, Harper, Jr. (M) ....Memphis, Tenn. Naval Air Station
Wright, Kenneth L. (M) ....Military Address Unknown
Wright, R. L. .....Poteau
Wright, W. T. .....Jay
Wynn, Noble F. .....Edmond
Wyrick, Richard .....Med. Arts Bldg., Okla. City

—Y—

Yagol, H. B. .....Ada
Yandell, Hays R. .....2020 S. Xanthus, Tulsa
Yeargan, W. M. (H) .....Hollis
Yeary, Edwin C. .....Ponca City
Yeary, G. H. .....Newkirk
York, J. F. .....Madill
Young, A. M., III .....Med. Arts Bldg., Okla. City
Young, B. O. .....Duncan
Young, C. C. .....Shawnee
Young, Edgar W., Jr. .....511 N.W. 11, Okla. City

SPECIAL MEMBERSHIPS - CLASSIFIED

ASSOCIATE MEMBERS

Everett, Mark R., Ph.D. .....801 N.E. 13, Okla. City
Gillick, David .....Talihina
Hansen, M. Fred, LL.B. .....Attorney General's Office
Hellbaum, Arthur A. .....801 N.E. 13, Okla. City
Lowenstein, Bernard .....New Mexico
Nichol, Byron A. .....Ft. Sill
Shoemaker, H. A., Ph.D. .....801 N.E. 13, Okla. City
Sutliff, Edward H. .....Clinton
Turley, Louis A. .....801 N.E. 13, Okla. City

JUNIOR MEMBERS

Baker, Charles .....1653 E. 12, Tulsa
Bartlett, F. L. .....1923 S. Utica, Tulsa
Berry, Spencer .....1923 S. Utica, Tulsa
Buchan, William H. .....Braniff Bldg., Tulsa
Calhoon, Edward .....1653 E. 12, Tulsa
Capehart, Maurice P. .....Med. Arts Bldg., Tulsa
Casey, Robert E. .....Rochester, Minnesota
Chevez, Hector .....1653 E. 12, Tulsa
Davis, George .....1653 E. 12, Tulsa
Felman, E. F. .....1923 S. Utica, Tulsa
Garrett, Claude .....1653 E. 12, Tulsa
Gomez, Francisco .....1653 E. 12, Tulsa
Haralson, P. H. .....1923 S. Utica, Tulsa
Harvey, Rosemary .....1653 E. 12, Tulsa
Hinton, Robert .....1653 E. 12, Tulsa
Johnson, Newman .....1653 E. 12, Tulsa
Johnson, R. Chadwick .....Sand Springs
Jones, Amy .....1653 E. 12, Tulsa
Knight, Arthur L. .....605 N.W. 10, Okla. City
Mays, W. G. .....1923 S. Utica, Tulsa
Neel, Roy L. .....950 E. 59th, Chicago 37, Ill.
Obert, Paul M. .....3931 Springlake Dr., Okla. City
Rafter, John R. .....Mission, Kansas
Shackelford, Paul O. .....General Delivery, Stony Brook, New York
Simpson, J. D. .....1923 S. Utica, Tulsa
Sledge, Claire B. .....St. Francis Hospital, Peoria, Ill.
Witten, Harold B. .....Gulfport, Miss.
Wooldridge, Bart F. .....2000 Haye St., Nashville, Tenn.

HONORARY MEMBERS

Alford, J. M. ..... Med. Arts Bldg., Okla. City
Beam, J. P. ..... Oakwood
Bitting, B. T. ..... Enid
Brookshire, J. E. ..... Ritz Bldg., Tulsa
Brown, Paul R. ..... 1614 E. 35, Tulsa
Camp, Earl ..... Buffalo
Cates, Albert M. ..... 2733 N.W. 20, Okla. City
Clinton, Fred S. ..... 230 E. Woodward Blvd., Tulsa
Coley, A. J. ..... 1929 N.W. Park, Okla. City
Comp, G. A. ..... Manitou
Cook, W. Albert ..... Med. Arts Bldg., Tulsa
Ewing, Finis W. ..... Surety Bldg., Muskogee
Grantham, Elizabeth ..... Alva
Hall, C. H. ..... 15 W. 3rd, Tulsa
Harber, J. N. ..... Phoenix, Arizona
Hooper, J. S. ..... Rt. No. 2, Rome, New York
Howell, O. E. ..... Norman
Jones, John Paul ..... Dill
Kerley, W. W. ..... Anadarko
Kingman, W. H. ..... Bartlesville
Lain, E. S. ..... Med. Arts Bldg., Okla. City
LaMotte, George A. ..... Colcord Bldg., Okla. City
Loyd, E. M. ..... Harlingen, Texas
Lucas, A. C. ..... Castle
Lyon, J. I. ..... Edmond
Maygimnes, P. H. ..... 1624 N. Norfolk, Tulsa
McClure, P. L. ..... Ft. Cobb
McKeel, Sam A. ..... Ada
Morrow, John A. ..... Sallisaw
Myers, David A. ..... 1250 Jines St., San Francisco, Calif.
Nesbitt, P. P. ..... 1565 Swan Drive, Tulsa
Postelle, Joseph M. ..... 611 W. Mulberry, San Antonio, Texas
Reed, Horace ..... 1200 N. Walker, Okla. City
Renfrow, T. F. ..... Billings
Reynolds, James L. ..... 1516 N. Cin., Tulsa
Richardson, D. P. ..... Union City
Richey, S. M. ..... Address Unknown
Riely, Lea A. ..... Rt. 1, Brooks Road, New Canaan, Conn.
Ross, S. P. ..... 1410 Camden Way, Okla. City
Sexton, C. E. ..... 1130 N.E. 10, Okla. City
Shipman, W. H. ..... Bartlesville
Simpson, N. N. ..... Henryetta
Speed, H. K. ..... Sayre
Tolleson, William A. ..... Eufaula
Warterfield, Floyd ..... Commercial Natl. Bank, Muskogee
White, J. Hutchings ..... Surety Bldg., Muskogee
Willour, L. S. ..... McAlester
Yeargan, W. M. ..... Hollis

LIFE MEMBERS

Anderson, Fred A. ..... Claremore
Andreskowski, W. T. ..... Elk City
Andrew, Leila E. ..... 509 N.W. 15, Okla. City
Athey, J. V. ..... Bartlesville
Berry, Thomas ..... El Dorado
Boon, U. C. ..... Chickasha
Boswell, H. D. ..... Henryetta
Breco, Joseph G. ..... Redondo Beach, California
Brown, Robert A. ..... Prague
Burns, S. L. ..... Stonewall
Cailey, Leo F. ..... Rt. 1, Box 165, Okla. City
Campbell, Hiram G. ..... Tecumseh
Chamberlin, Elizabeth ..... Bartlesville
Charbonnet, P. N. ..... Box 41, Pass Christian, Miss.
Childs, J. W. ..... Med. Arts Bldg., Tulsa
Clark, J. B. ..... Coalgate
Cochrane, J. E. ..... Byars
Cody, Robert D. ..... Centrahoma
Collins, D. B. ..... Waurika
Cook, W. H. ..... Chickasha
Coulter, Thomas B. ..... Med. Arts Bldg., Tulsa
Crow, Emory S. ..... Olustee
Davis, George M., Sr. ..... Bixby
Day, John L. ..... Woodward
Dixon, Ambrose ..... Hennessey
Dougan, A. L. ..... Carmen
Downey, D. S. ..... Chickasha
Ellis, H. A. ..... Kiowa
Farris, H. Lee ..... 2214 E. 25th St., Tulsa
Flesher, Thomas H. ..... Edmond
Gilliam, William C. ..... Spiro
Gray, Dan F. ..... Guthrie
Haas, H. R. ..... Disney
Hahn, L. A. ..... Guthrie
Harbison, J. E. ..... 1625 Marion, Okla. City
Hardy, Walter ..... Ardmore
Haskett, Paul E. ..... 1941 N.W. 19, Okla. City
Hathaway, A. H. ..... Mountain View
Hawn, W. T. ..... Binger
Hayes, R. B. ..... Guymon
Henderson, F. W. ..... 1647 E. 1st, Tulsa
Hill, C. B. ..... Guthrie
Hines, S. J. T. ..... Tahlequah
Hobbs, A. F. ..... Hinton
Howard, R. M. ..... 815 N.W. 15, Okla. City
Huston, H. E. ..... Kiowa, Kansas
Johnson, R. R. ..... Sand Springs
Johnson, Walter ..... Ardmore
Lansden, J. B. ..... Granite
Larkin, H. W. ..... Guthrie
Leachman, T. C. ..... Richmond, Va.
LeBlanc, William ..... Ochelata
LeHew, J. L., Sr. ..... Pawnee
LeMaster, D. W. ..... Wayne
Leslie, S. B., Sr. ..... Okmulgee
Love, R. S. ..... 2701 N.W. 19, Okla. City
Lynch, Thomas J. ..... 2132 E. 24, Tulsa
Mabry, W. L. ..... Leedey
Martin, J. T. ..... 3110 Harvey Parkway, Okla. City
Matheney, J. C. ..... Okmulgee
McBrayer, W. H. ..... Idabel
McCalib, D. C. ..... Colbert
McConnell, L. H. ..... Altus
McVey, G. M. ..... Verden
Minor, S. W. ..... Hinton
Mitchener, W. C. ..... Okmulgee
Mohrman, Silas S. ..... 1818 E. 15, Tulsa
Moth, M. V. ..... 2001 N. Lottie, Okla. City
Murray, Silas ..... Med. Arts Bldg., Tulsa
O'Leary, D. W. ..... Norman
Perry, Daniel ..... 222 E. 5th, Tulsa
Petty, C. S. ..... Guthrie
Pigford, R. C. ..... 2427 E. 26th, Tulsa
Poer, E. M. ..... Mangum
Presson, L. C. ..... 1948 N. Main, Tulsa
Ralston, B. W. ..... Commerce
Reese, C. B. ..... Sapulpa
Renegar, J. F. ..... Tuttle
Rhodes, R. E. L. ..... 2220 S. St. Lewis, Tulsa
Rhodes, William H. ..... 1714 W. Okla., Enid
Rice, O. W. ..... McAlester
Robberson, Marvin E., Sr. ..... Wynnewood
Roberts, D. D. ..... 1631 E. Bdwy., Enid
Roberts, S. P. ..... Nowata
Rucks, W. W., Sr. ..... 301 N.W. 12, Okla. City
Rutherford, S. C. ..... Locust Grove
Sanger, Winnie M. ..... 921 N.W. 23, Okla. City
Seaborn, T. L. ..... Ada
Shelton, J. W. ..... Los Angeles, Calif.
Shi, Augustin H. ..... Stratford
Smith, Joseph G. ..... Bartlesville
Somerville, O. S. ..... Bartlesville
Stallings, T. W. ..... 724 S. Elgin, Tulsa
Taylor, W. M. ..... 925 N.W. 17, Okla. City
Templin, O. E. ..... Alva
Tompkins, J. E. ..... Yukon
Torrey, J. P. ..... Bartlesville
Venable, Sidney C. ..... 1757 S. Columbia, Tulsa
Wait, Will C. ..... McAlester
Wallace, J. E. ..... 1323 S. Peoria, Tulsa
Watkins, B. H. ..... Hobart
Westfall, L. M. ..... 1502 Wilshire Blvd., Okla. City
Wharton, J. L. ..... Depew
Williams, C. O. ..... McAlester
Williams, R. W. ..... Evergreen, Colorado
Wolf, Llewellyn G. ..... Okarche

ROSTER BY COUNTIES

MEMBERS OF THE OKLAHOMA STATE MEDICAL ASSOCIATION AS OF DECEMBER 31, 1952

(AP) Application Pending
(A) Associate Members
(F) Fifty Year Pin
(H) Honorary Members
(J) Junior Members
(L) Life Members
(M) Military

(Classified Listiug of Associate, Honorary, Junior and Life Members may be found on Page 23)

ADAIR COUNTY

Emmott, Ralph C. ....Stilwell
(Member Cherokee County Society)
Green, B. F. ....Stilwell
(Member Cherokee County Society)

ALFALFA COUNTY

Benson, Charles L. ....Cherokee
Blender, John X. ....Cherokee
Dougan, A. L. (L) (F) ....Carmen
Hale, Forrest ....Cherokee
Harris, G. G. ....Helena
Huston, H. E. (L) ....Kiowa, Kansas
Kirby, L. R. ....Cherokee
Weber, A. G. ....Goltry
(Member Garfield-Kingfisher County Society)

ATOKA COUNTY

Fina, A. C. ....Atoka
Rahhal, George ....Atoka
(Member Pittsburg County Society)
Thompson, James B. ....Atoka
(Member Pittsburg County Society)

BEAVER COUNTY

Benjegerdes, Theodore ....Beaver
(Member Woods County Society)
McGrew, E. A. ....Beaver

BECKHAM COUNTY

Andreskowski, W. T. (L) ....E'k City
(Member Jefferson County Society)
Baker, L. V. ....Elk City
Devanney, Phil J. ....Sayre
Evans, Leo R. ....Sayre
Featherston, Wm. M. ....Elk City
Husband, Wm. G. (AP) ....Elk City
Kilpatrick, E. S. ....Elk City
Leebron, Wm. M. ....Elk City
Lehman, Donald S. ....Elk City
McGrath, Thomas J. ....Sayre
Meiers, R. L. (M) ....V. A. Hospital, Topeka, Kansas
Parker, James W. ....Elk City
Shadid, Alexander ....Elk City
Shadid, Fred V. ....Elk City
Speed, H. K. (H) ....Sayre
Spence, W. P. ....Sayre
Standifer, O. C. ....Elk City
Sugarman, Milton J. ....Elk City

BLAINE COUNTY

Anderson, H. R. ....Watonga
Bohlman, W. F. ....Watonga
Cox, A. K. ....Watonga
Curtiu, Virginia ....Watonga
De Jarnette, John F., Jr. ....Geary
Godfrey, Kenneth E. ....Okeene
McLaughlin, Roberta A. (M) ....Montgomery, Alabama
Milligan, E. F. ....Geary
Perry, Fred T. ....Watonga
Rogers, C. L. ....Watonga
Steugh, Daniel F., Jr. ....Geary
Williams, Claude H. ....Okeene

BRYAN COUNTY

Baker, A. T. ....Durant
Cochran, Roy L. ....Caddo
Coker, B. B. ....Durant
Colwick, J. T. ....Durant
Engles, Leroy L. ....Durant
Haynie, W. K. ....Durant
Hyde, W. A. ....Durant
McCalib, D. C. (L) ....Colbert
Moore, Charles F. ....Durant
Sawyer, R. E. ....Durant
Whitely, Seals L., Jr. ....Durant
Williams, J. C. ....Durant

CADDO COUNTY

Conover, George W., Jr. ....Anadarko
Cock, Edward T., Jr. ....Anadarko
Dixon, W. L. ....Cement
Haslam, G. E. ....Anadarko
Hawn, W. T. (L) ....Binger
Henke, J. R. ....Hydro
Hobbs, A. F. (L) (F) ....Hinton
Kerley, W. W. (H) ....Anadarko
McClure, P. L. (H) ....Fort Cobb
McMillan, C. B. ....Gracemont
Mayes, R. H. ....Anadarko
Miles, John B. ....Anadarko
Minor, S. W. (L) ....Hinton
Sullivan, C. B. ....Carnegie
Waterbury, C. R. ....Apache
Williams, R. W. (L) ....Evergreen, Colorado

CANADIAN COUNTY

Catto, W. B. ....El Reno
Enos, Jack P. ....Yukon
Goldberger, Joseph H. ....El Reno
Goodman, George L. ....Yukon
Herod, Philip F. ....El Reno
Jobe, James P. (AP) ....El Reno
Johnson, A. L. ....El Reno
Lawton, W. P. ....El Reno
Mogab, John ....El Reno

Myers, Jack W. ..... El Reno
Neumann, Milton A. ..... Okarche
Phelps, Joseph T. ..... El Reno
Phelps, Malcom E. ..... El Reno
Richardson, D. P. (F) (H) ..... Union City
Riley, James T. ..... El Reno
Strong, C. Riley ..... El Reno
Tomkins, J. E. (L) ..... Yukon
Walker, Ethan A. ..... Yukon
Wolf, Llewellyn G. (L) ..... Okarche

CARTER COUNTY

Barker, E. R. ..... Healdton
Cantrell, D. E., Jr. ..... Healdton
Carlock, J. Hoyle ..... Ardmore
Cox, J. L. ..... Ardmore
Cunningham, C. D. ..... Ardmore
Godfrey, James T., Jr. ..... Ardmore
Gordon, J. M. ..... Ardmore
Graybill, Ray B. ..... Ardmore
Hardy, Walter (L) (F) ..... Ardmore
Hathaway, W. G. ..... Lone Grove
Horne, Malcolm ..... Ardmore
Jesse, Claron H. ..... Ardmore
Johnson, G. E. ..... Ardmore
Johnson, Walter (L) ..... Ardmore
Karlick, Joseph R. ..... Ardmore
Kell, Thornton ..... Ardmore
Long, Lloyd L., Jr. ..... Ardmore
Maloney, V. J., Jr. ..... Ardmore
Means, Royce B. (M) ..... Ft. Sill
Mote, W. R. ..... Ardmore
Moxley, Joe N. ..... Ardmore
Pollock, John R., Jr. ..... Ardmore
Reid, Roger I. ..... Ardmore
Ryan, Henry G. II (M) c/o P.M. San Francisco, Calif.
Sullivan, R. C. ..... Ardmore
Truman, A. W. ..... Ardmore
Veazey, J. H. ..... Ardmore
Veazey, Lyman C. ..... Ardmore
Walker, Ethel M. ..... Ardmore
White, J. H. ..... Ardmore

CHEROKEE COUNTY

Allison, John S. (F) ..... Tahlequah
Buffington, G. W. ..... Tahlequah
Canada, J. C. ..... Tahlequah
Hines, S. J. T. (L) ..... Tahlequah
McIntosh, R. K., Jr. ..... Tahlequah
Masters, H. A. ..... Tahlequah
Medearis, P. H. ..... Tahlequah

CHOCTAW COUNTY

Gee, R. L. (F) ..... Hugo
Hoke, Lillian ..... Hugo
Johnson, E. A. ..... Hugo
Waters, Floyd L. ..... Hugo
Wolfe, Henry D. ..... Hugo

CIMARRON COUNTY

Bayless, James ..... Boise City
Hall, Harry B. ..... Boise City
Oxley, W. N. ..... Texhoma

CLEVELAND COUNTY

Atkins, W. H. ..... Norman
Berry, John Curtis ..... Norman
Buffington, F. C. ..... Norman
Fox, William W. ..... Norman
Gillespie, C. P. ..... Norman
Gregg, O. R. ..... Norman
Hackler, H. W. ..... Norman
Haddock, James L., Jr. ..... Norman
Haddock, Phil ..... Norman
Hinshaw, J. R. ..... Norman
Hohl, James F. (M) ..... 37 Aldrich Rd., Apt. 1, Watertown, Mass.
Hood, James O. ..... Norman
Howell, O. E. (H) ..... Norman
Lambert, J. B. ..... Lexington
Mayfield, W. T. ..... Norman
Merritt, Iva S. ..... Norman
Mitchell, Clarence ..... Norman
Mosley, Kirk T. ..... Norman
Nicholson, James L. ..... Norman
Nielsen, Gertrude ..... Norman
O'Leary, D. W. (L) ..... Norman
Ragan, T. A. ..... Norman
Reichert, R. J. ..... Norman
Ryan, Robert O. ..... Norman
Smith, Charles A. ..... Norman
Stephens, Edward F. ..... Norman
Wickham, M. M. ..... Norman
Willard, D. G. ..... Norman
Nitten, H. B. (J) ..... Gulfport, Miss.
Woodson, O. M. ..... Norman

COAL COUNTY

Byrd, Wallace ..... Coalgate
(Member Pontotoc County Society)
Clark, J. B. (L) (F) ..... Coalgate
Cody, Robert D. (L) ..... Centrahoma

COMANCHE COUNTY

Angus, Donald A. ..... 614 "C" Street, Lawton
Angus, Hancy A. ..... 614 "C"' Street, Lawtou
Angus, Howard ..... 614 "C" Street, Lawton
Aycock, Byron ..... 608½ "C" Lawton
Barber, George S. ..... 430½ "D" Ave., Lawton
Cole, W. C. ..... 605 Gore Blvd., Lawton
Dennis, Robert P. ..... 608½ "C" Street, Lawton
Donaghe, Roy W. ..... 605 Gore Blvd., Lawton
Downing, G. G. ..... 605 Gore Blvd., Lawton
Dunlap, Ernest B. ..... 513 "E" Ave., Lawton
Evans, H. M. ..... 214 South Fourth, Lawton
Ferguson, Lawence W. ..... 509 "E" Ave., Lawton
Fox, Fred T. ..... 605 Gore Blvd., Lawton
Graybill, Charles S. ..... 605 Gore Blvd., Lawtou
Green, Charles E. ..... 605 Gore Blvd., Lawton
Hamm, Leslie T. ..... Koehler Bldg., Lawton
Hicks, J. T., Jr. (AP) ..... 605 Gore Blvd., Lawton
Howard, Herbert ..... 605 Gore Blvd., Lawton
Jones, Delmas B. ..... Norton, Va.
Joyce, Charles W. ..... Fletcher
Lewis, W. F. ..... 605 Gore Blvd., Lawton
McDonald, Justin J. ..... Coffeyville, Kansas
Martin, Chelsey M. ..... Elgin
Matthey, William A. ..... 1904½ Ferris, Lawton
Mitchell, Joseph N. ..... Koehler Bldg., Lawton
Myers, David A. (H) ..... San Francisco, California
Nichol, Byron A., Lt. Col. (A) ..... Ft. Sill, Oklahoma
Parsons, O. L. ..... 511 "E" Ave., Lawton
White, L. M. (AP) ..... 614 "C" Ave., Lawton
Wicker, Walter, Jr. ..... 605 Gore Blvd., Lawton

COTTON COUNTY

Baker, George W. (F) ..... Walters
Scism, Mollie ..... Walters
Smith, Henry C. ..... Walters

CRAIG COUNTY

Adams, Felix M., Sr. ..... Vinita
Adelman, Frank L. ..... Vinita
Bradshaw, J. O. ..... Welch
Darrough, James B. ..... Vinita
Hays, P. L. ..... Vinita
Lehmer, Elizabeth E. ..... Vinita
McMilian, J. M. ..... Vinita
Marks, W. R. ..... Vinita
Olson, Donald H. ..... Vinita
Witcher, Edward K. ..... Vinita

CREEK COUNTY

Bakken, Richard L. ..... Bristow
Bowie, Carl W. (M) ..... Military Address Unknown
Burnett, Thomas D. ..... Sapulpa

Cale, Walter (M) .....Ft. Sam Houston, Texas
Coppedge, O. C. .....Bristow
Coppedge, O. S. .....Depew
Curry, J. F. .....Sapulpa
Haas, H. R. (L) .....Disney
Hindeman, W. M. .....Detroit, Michigan
Hollis, J. E. .....Bristow
Joseph, Philip G. .....Sapulpa
King, E. W. .....Bristow
Lewis, P. K. .....Sapulpa
Loescher, Thomas M. .....Sapulpa
McAllister, D. W. .....Bristow
Martin, Louis A. .....Sapulpa
Mote, Paul .....Sapulpa
Oakes, Charles G. .....Sapulpa
Reese, C. B. (L) .....Sapulpa
Reynolds, S. W. .....Drumright
Schmidt, Loraine .....Sapulpa
Simpson. J. D. .....Sapulpa
Sisler, Frank H. .....Bristow
Starr, O. W. .....Drumright
Wharton, J. L. (F) (L) .....Depew
Woodard, C. E. .....Drumright

CUSTER COUNTY

Alexander, C. J. .....Clinton
Brundage, Bert T. .....Thomas
Cunningham, C. B. .....Clinton
Deputy, Ross .....Clinton
Dewberry, Glenn P. .....Clinton
Lain, W. B. .....Clinton
Lamb, Ellis .....Clinton
Lingenfelter, Paul B. .....Clinton
Loyd, E. M. (H) .....Harlingen, Texas
McGolrick, Jack B. (M) .....APO 25 c/o P.M., San Francisco, Calif.
Redus, Lonnie C. .....Weatherford
Rentfrow, James W. .....Clinton
Rogers, McLain .....Clinton
Simon, Floyd .....Clinton
Simon, Ralph .....Clinton
Stoll, A. A. .....Clinton
Sutliff, Edward H. (A) .....Clinton
Tisdal, James H. .....Clinton
Tisdal, W. C. .....Clinton
Vieregg, F. R. .....Clinton
Williams, Gordon D. .....Weatherford
Wood, J. Guild .....Weatherford

DELAWARE COUNTY

Wright, W. T. .....Jay
(Member Ottawa-Craig County Society)

DEWEY COUNTY

Beam, J. P. (H) (F) .....Oakwood
McNeal, Don .....Military Address Unknown
Mabry, W. L. (L) .....Leedey
(Member Beckham County Society)
Seba, W. E. .....Leedey
(Member Beckham County Society)

ELLIS COUNTY

Burgtorf, Richard H. (AP) .....Shattuck
Dersch, Walter H., Jr. .....Shattuck
Newman, Floyd .....Shattuck
Newman, M. Haskell .....Shattuck
Newman, O. C. (F) .....Shattuck
Newman, Roy .....Shattuck
Smith, Joseph J. .....Shattuck

GARFIELD COUNTY

Baker, Roscoe C. .....1223 W. Maine, Enid
Bank, Edward W., Jr. .....Broadway Tower, Enid
Bitting, B. T. (H) (F) .....1721 W. Maine, Enid
Chambers, E. Evans .....610 S. Monroe, Enid
Champlin, Paul B. .....First Nat'l Bank Bldg., Enid
Cordonnier, Byron, Jr. .....Broadway Tower, Enid
Dougan, A. F. .....Broadway Tower, Enid
Duffy, Francis M. .....211 W. Maple, Enid
Field, Julian .....610 S. Monroe, Enid
Francisco, Glenn .....Bass Bldg., Enid
Hall, R. L. .....Bass Bldg., Enid
Hamble, V. R. .....Broadway Tower, Enid
Harris, D. S. .....Drummond
Herlihy, Robert M. .....Broadway Tower, Enid
Hinson, Bruce R. .....330 S. 5th, Enid
Holcomb, Mark D. .....Broadway Tower, Enid
Hopkins, P. W. .....Broadway Tower, Enid
Hudson, Fred A. .....610 S. Monroe, Enid
Hudson, Harry H. .....610 S. Monroe, Enid
Hyer, J. V. .....Garber
Jacobs, Raymond G. .....310 S. 5th St., Enid
McIntyre, John A. .....Broadway Tower, Enid
Mercer, Wendall J. .....First Nat'l Bank Bldg., Enid
Neilson, William P. .....Broadway Tower, Enid
Newell, W. B., Sr. .....Broadway Tower, Enid
Newell, W. B., Jr. .....230 S. 5th St., Enid
Rempel, Paul H. .....Broadway Tower, Enid
Rhodes, William H. (L) .....1724 W. Oklahoma, Enid
Roberts, Charles J. .....610 S. Monroe, Enid
Roberts, D. D. (L) .....1631 E. Broadway, Enid
Robinson, Earl M. .....First Nat'l Bank Bldg., Enid
Robinson, Earl W. .....610 S. Monroe, Enid
Robinson, Lillian H. .....610 S. Monroe, Enid
Rollins, James H. .....610 S. Monroe, Enid
Rose, Dayton M. (M) .....Vance A.F.B., Enid
Ross, George T. .....First Nat'l Bank Bldg., Enid
Ross, Hope S. .....First Nat'l Bank Bldg., Enid
Sheets, Marion E. .....310 S. 5th St., Enid
Shields, Herbert B. .....Broadway Tower, Enid
Shyrock, Leland F. .....Broadway Tower, Enid
Shuttee, Robert D. .....First Nat'l Bank Bldg., Enid
Tagge, James Frederick.....First Nat'l Bank Bldg., Enid
Talley, E. Evans .....Broadway Tower, Enid
Terrill, Robert J. .....610 S. Monroe, Enid
Vandever, H. F. .....First Nat'l Bank Bldg., Enid
Wight, Avery B. .....Bass Bldg., Enid
Wilson, George S. .....610 S. Monroe, Enid

GARVIN COUNTY

Byrd, J. N., Jr. (M) .....Military Address Unknown
Graham, J. A. .....Pauls Valley
Lindsey, Ray H. .....Pauls Valley
Monroe, Hugh H. .....Pauls Valley
Robberson, Marvin E., Sr. (L) .....Wynnewood
Robberson, Morton E., Jr. .....Wynnewood
Shi, Augustin H. (F) (L) .....Stratford
Shirley, Edward T. .....Wynnewood
Smith, William Howard (M) Military Address Unknown
Spence, Ray E. .....Pauls Valley
Steen, Carl T. .....Pauls Valley
Waltrip, Jesse R. .....Pauls Valley
Wilson, Donald J. .....Pauls Valley

GRADY COUNTY

Baze, Walter J. .....Chickasha
Bonne'l, William .....Chickasha
Boon, U. C. (L) (F) .....Chickasha
Chatham, Beverly C. .....Chickasha
Coates, R. R. .....Chickasha
Cook, W. H. (L) .....Chickasha
Davis, Wesley W. .....Chickasha
Downey, D. S. (L) .....Chickasha
Foertsch, J. H. .....Chickasha
Gyles, Wm. T. .....Rush Springs
Hairston, R. M. .....Chickasha
Henton, R. H. (AP) .....Rush Springs
Holman, James H. .....Tipton
Hoyt, Arthur W. .....Chickasha
Little, A. C. .....Minco
Macumber, H. H. .....Chickasha
Mason, Rebecca H. .....Chickasha
McClure, H. M. .....Chickasha
McDougal, Burton B. .....Chickasha
McVey, G. M. (L) .....Verden
Ohl, Charles W. .....Chickasha
Renegar, J. F. (L) .....Tuttle
Revere, Seth D. .....Chickasha
Shelby, Richard D. .....Chickasha

Stoll, Richard G. ..... Chickasha
Swan, Joseph J. ..... Chickasha
Woods, Lewis E. ..... Chickasha

GRANT COUNTY

Choice, R. W. ..... Wakita
Robinson, F. P. ..... Pond Creek
Stalker, Harry A. (F) ..... Pond Creek

GREER COUNTY

Ambrister, J. W. ..... Granite
Coggins, Farris W. (M) A.P.O. 108, c/o P.M., New York
Fried, David ..... Mangum
Hollis, J. B. ..... Mangum
Lansden, J. B. (L) (F) ..... Granite
Parmley, Van S. ..... Mangum
Pierson, Dwight D. ..... Mangum
Poer, E. M. (L) (F) ..... Mangum
Sellers, Fred W. ..... Mangum
Wainwright, Tom L. ..... Mangum

HARMON COUNTY

Lynch, R. H. ..... Hollis
(Member Greer County Society)
Srigley, R. S. ..... Hollis
(Member Jackson County Society)
Street, O. J. (H) ..... Gould
Yeargan, W. M. (H) ..... Hollis

HARPER COUNTY

Camp, Earl (H) ..... Buffalo

HASKELL COUNTY

Carson, William S. ..... Keota
Williams, N. K. ..... McCurtain

HUGHES COUNTY

Bloss, C. M., Jr. ..... Holdenville
Cramblett, Denny H. ..... Holdeuville
Hamilton, S. H. ..... Non
Hicks, C. A. ..... Holdenville
Johnston, L. A. S. ..... Holdenville
Kernek, Clyde ..... Holdenville
Kernek, Paul ..... Holdenville
Pryor, V. W. ..... Holdenville
Schaff, Hartzell V. ..... Holdenville
Slagle, Gene W. (M) ..... U.S. Naval Hospital, Memphis, Tenn.

JACKSON COUNTY

Abernethy, Edward A. ..... Altus
Abernethy, James H. ..... Altus
Allgood, E. J. ..... Altus
Allgood, J. M. ..... Altus
Asher, James O. ..... Altus
Becker, Fred W. ..... Altus
Berry, Thomas (L) (F) ..... Eldorado
Bussey, Hugh N. ..... Altus
Crow, Emory S. (L) (F) ..... Olustee
Ensey, James E. ..... Altus
Holt, Willard D. ..... Altus
Irby, J. P. ..... Altus
Mabry, Earl W. ..... Altus
McConnell, L. H. (L) (F) ..... Altus
Mollison, Malcolm ..... Altus
Starkey, Wayne A. ..... Altus
Taylor, R. Z. ..... Blair
Tefertiller, Charles L. ..... Altus
Wooldridge, Bart F. (J) ..... 2000 Hayes St., Nashville, Tennessee

JEFFERSON COUNTY

Collins, D. B. (L) (F) ..... Waurika
Hagg, O. J. ..... Waurika
Heflin, W. A. ..... Ryan
Jacob, John B. ..... Waurika
Kouri, Phillip, (M) ..... APO. 1054, c/o P.M., San Francisco, Calif.
Rosier, Harold A. ..... Waurika

JOHNSON COUNTY

Scott, G. W. ..... Tishomingo
(Member Pontotoc County Society)

KAY COUNTY

Armstrong, W. O. ..... Ponca City
Arrendell, C. W., Jr. (M) ..... New Orleans, La.
Arrendell, C. W., Sr. ..... Ponca City
Arrendell, Eugene H. ..... Ponca City
Beatty, J. H. ..... Tonkawa
Becker, L. H. ..... Blackwell
Bush, Jordon M. ..... Ponca City
Clift, Merl ..... Blackwell
Cooper, N. H. ..... Ponca City
Gardner, C. C. ..... Ponca City
Ghormley, J. G. ..... Blackwell
Gibson, R. B. ..... Ponca City
Gibson, R. W. ..... Ponca City
Gilbert, John B. ..... Ponca City
Glasscock, Thomas C. ..... Ponca City
Gowey, H. O. ..... Newkirk
Howe, J. Holland ..... Ponca City
Kinsinger, R. R. ..... Blackwell
Kreger, Glen S. ..... Tonkawa
Kreger, J. Russell ..... Tonkawa
McElroy, Thomas ..... Ponca City
MacKercher, Peter A. ..... Ponca City
Mall, W. W. ..... Ponca City
Mathews, Dewey ..... Tonkawa
Merrifield, Vernon C. ..... Ponca City
Mohler, E. C. ..... Ponca City
Neal, L. G. ..... Ponca City
Niemann, George H. ..... Ponca City
Northcutt, C. E. ..... Ponca City
Nuckols, A. S. ..... Ponca City
Powell, Paul T. ..... Ponca City
Risser, A. S. ..... Blackwell
Rome, Albert (AP) ..... Ponca City
Schneble, Richard J. ..... Ponca City
Terry, Jack T. ..... Ponca City
Waggoner, E. E. ..... Tonkawa
Wagner, J. C. ..... Ponca City
Walker, I. D. ..... Tonkawa
White, M. S. ..... Blackwell
Yeary, Edwin C. ..... Ponca City
Yeary, G. H. ..... Newkirk

KINGFISHER COUNTY

Dixon, Ambrose (L) ..... Hennessey
Hodgson, C. M. ..... Kingfisher
Lattimore, Frank C. ..... Kingfisher
McIntyre, Ray V. (AP) ..... Kingfisher
Ottis, Paul J. ..... Okarche
Pendleton, Jno. W. ..... Kingfisher
Smith, Francis E. (AP) ..... Kingfisher
Sturgeon, H. Violet ..... Hennessey
Taylor, John R. ..... Kingfisher

KIOWA COUNTY

Allgood, E. A. ..... Snyder
(Member Jackson County Society)
Bernell, William ..... Hobart
Braun, J. P. ..... Hobart
Finch, J. William ..... Hobart
Hathaway, A. H. (L) (F) ..... Mountain View
Mahone, M. Wilson ..... Hobart
Phelan, Ralph S. ..... Hobart
Tolbert, J. B. ..... Mountain View
Watkins, B. H. (L) ..... Hobart

LATIMER COUNTY

Booth, G. R., Sr. ..... Wilburton
(Member LeFlore-Haskell County Society)
Booth, G. R., Jr. ..... Wilburton
(Member Pittsburg County Society)

LEFLORE COUNTY

Baker, Forrest P. ..... Talihina
Bevill, S. D. ..... Poteau
Bradley, Frank L. ..... Talihina
Collins, E. L. (F) ..... Panama
Cotton, W. W. ..... Poteau
Cunningham, Charles S. ..... Poteau
Dean, S. C. (F) ..... Howe
Fair, E. N. ..... Heavener
Gilliam, William C. (L) (F) ..... Spiro
Gillick, David (A) ..... Talihina
Harvey, John H. ..... Heavener
Hogaboom, G. M. ..... Heavener
Lowrey, Robert W. ..... Poteau
Minor, R. W. ..... Spiro
Rigual, Rafael ..... Wister
Saviers, Boyd M. (M) ..... M.O.Q. No. 6 Cabaness Field, Corpus Christi, Texas
Woodson, E. M. ..... Poteau
Wright, R. L. ..... Poteau

LINCOLN COUNTY

Bailey, Carl H. ..... Stroud
Baugh, Harold T. ..... Meeker
Brown, Robert A. (L) (F) ..... Prague
(Member Pottawatomie County Society)
Burleson, Ned ..... Prague
Demas, Ross P. ..... Stroud
Gallaway, Nova Linda (AP) ..... Prague
Groves, Gene (M) (AP) ..... Military Address Unknown
Mileham, Jack C. ..... Chandler
Robertson, C. W. ..... Chandler
Rollins, John Gordon (AP) ..... Prague

LOGAN COUNTY

Barker, Pauline ..... Guthrie
Fife, Phillips R. ..... Guthrie
Gray, Dan F. (L) (F) ..... Guthrie
Hahn, L. A. (L) ..... Guthrie
Hill, C. B. (L) ..... Guthrie
Larkin, H. W. (L) ..... Guthrie
LeHew, Elton W. ..... Guthrie
LeHew, J. L., Jr. ..... Guthrie
Merrell, Webber W. ..... Guthrie
Miller, W. C. ..... Guthrie
Petty, C. S. (L) (F) ..... Guthrie
Petty, James S. ..... Guthrie
Ringrose, R. F. ..... Guthrie
Ritzhaupt, Louis H. ..... Guthrie
Souter, J. E. ..... Guthrie

LOVE COUNTY

Lawson, Pat ..... Marietta

McCLAIN COUNTY

Berkenbile, Glen L. ..... Purcell
Cochran, J. E. (L) ..... Byars
Kolb, I. N. ..... Blanchard
McCurdy, W. C., Jr. ..... Purcell
Royster, R. L. ..... Purcell

McCURTAIN COUNTY

Clarkson, A. M. ..... Idabel
Gee, L. E. (F) ..... Broken Bow
Hale, A. Eugene ..... Idabel
(Member Pittsburg County Society)
Howard, Thomas D. ..... Idabel
McBraver, W. H. (L) ..... Idabel
Rhea, Thomas E. ..... Idabel

McINTOSH COUNTY

Baker, J. Howard, Jr. ..... Eufaula
First, F. R., Jr. ..... Checotah
First, F. R. ..... Checotah
Tolleson, William A. (F) (H) ..... Eufaula
Wendel, Wm. E., Jr. ..... Eufaula
Wood, James L. ..... Eufaula

MAJOR COUNTY

McCroskie, M. R. ..... Fairview
(Member Garfield-Kingfisher County Society)
Smith, Donald H. ..... Fairview
(Member Garfield-Kingfisher County Society)

MARSHALL COUNTY

Cook, Odis A. ..... Madill
Raff, Joseph S. ..... Madill
York, J. F. ..... Madill

MAYES COUNTY

Cameron, Paul B. ..... Pryor
Gwartney, Warren G. ..... Pryor
Lembke, Robert L. ..... Pryor
Morrow, B. L. ..... Salina
Rutherford, S. C. (L) ..... Locust Grove
Werling, E. H. ..... Pryor

MURRAY COUNTY

Delay, W. D. ..... Sulphur
(Member Carter-Love-Marshall County Society)
Lewis, R. W. ..... Sulphur
(Member Pontotoc County Society)
Morton, R. W. ..... Sulphur

MUSKOGEE COUNTY

Ballentine, H. T. ..... Manhattan Bldg., Muskogee
Beaty, Charles S. ..... 2211 Callahan St., Muskogee
Chumley, C. P. ..... General Delivery, Muskogee
Cronk, Robert T. (AP) ..... Fite Clinic, Muskogee
Dorwart, F. G. ..... 510 South 11th St., Muskogee
Doyle, W. H. ..... 443 No. 16th St., Muskogee
Earnest, A. N. ..... Barnes Bldg., Muskogee
Elkins, Marvin ..... Barnes Bldg., Muskogee
Endres, R. K. (M) ..... Military Address Unknown
Ewing, Finis (H) ..... Surety Bldg., Muskogee
Fite, E. Halsell ..... 443 No. 16th St., Muskogee
Fite, W. Pat ..... 443 No. 16th St., Muskogee
Fite, William Pat, Jr. (AP) 443 No. 16th St., Muskogee
Fullenwider, C. G. ..... Barnes Building, Muskogee
Gafford, Thomas ..... Baptist Hospital, Muskogee
Gephardt, Maurice C. ..... Veterans Hospital, Muskogee
Gray, Virgil B., Jr. ..... Surety Building, Muskogee
Hackler, John F. ..... South 3rd St., Muskogee
Hamm, Silas G. ..... Haskell
Henry, Eugene M. ..... 204 No. 3rd St., Muskogee
Holcombe, R. N. ..... Surety Building, Muskogee
Horn, John E. ..... 1620 W. Okmulgee, Muskogee
Johnson, Porteous ..... Surety Bldg., Muskogee
Johnson, S. E. ..... 309 Commercial Nat'l Bldg., Muskogee
Kaiser, George L. ..... Manhattan Bldg., Muskogee
Klass, O. C. ..... Surety Bldg., Muskogee
Kupka, John F. ..... Haskell
Lipnick, Louis ..... V.A. Regional Office, Muskogee
McAlister, L. S. ..... Barnes Bldg., Muskogee
Mathews, Virgil D. ..... Surety Bldg., Muskogee
Miller, D. Evelyn ..... Honor Heights Dr., Muskogee
Neely, Shade ..... Commercial Nat'l Bldg., Muskogee
Oglesbee, Carson L. ..... Manhattan Bldg., Muskogee
Oldham, I. B. ..... 426 No. 6th St., Muskogee
Pratt, T. W. ..... V.A. Hospital, Muskogee
(Member Ottawa-Craig County Society)
Rafter, John R. (J) ..... Mission, Kansas
Reynolds, Jack ..... Barnes Bldg., Muskogee
Reynolds, John H. ..... First Nat'l Bank Bldg., Muskogee
Sanders, Harmon U. ..... 228 East 32nd St., Kansas City, Missouri
Scott, H. A. ..... Commercial Nat'l Bldg., Muskogee
Steelman, G. M. ..... Haskell
Thompson, M. K. (F) ..... Surety Bldg., Muskogee
Tracy, Gilbert W. (AP) ..... 1524 W. Okmulgee Ave., Muskogee
Turner, R. D. ..... Barnes Bldg., Muskogee
Warterfield, Floyd (F) (H) ..... Commercial Nat'l Bldg., Muskogee
Weaver, Wm. N. ..... Manhattan Bldg., Muskogee
White, Charles Ed ..... 526 No. 6th St., Muskogee
White, J. Hutchings (F) (H) ..... Surety Bldg., Muskogee

Wolfe, I. C. ....426 No. 6th St., Muskogee
Wood, W. M. ....Barnes Bldg., Muskogee
Woodburn, Joel T. ....Barnes Bldg., Muskogee

NOBLE COUNTY

Brown, A. M., Jr. ....Perry
Cooke, C. H. ....Perry
Dougherty, Raymond J., Jr. ....Perry
Driver, J. W. ....Perry
Evans, A. M. ....Perry
Francis, J. W. ....Perry
Renfrow, Thomas F. (H) ....Billings
Simon, Bill J. ....Perry

NOWATA COUNTY

Adams, Felix M., Jr. ....Nowata
Grigsby, O. L. ....Nowata
Lang, S. A. ....Nowata
Prentiss, H. M. ....Nowata
Roberts, S. P. (L) ....Nowata

OKFUSKEE COUNTY

Brasfield, John A. ....Okemah
Capehart, Samuel A. (M) ....Brooks Army Hospital, Ft. Sam Houston. Texas
Cochran, C. M. ....Okemah
Gissler, Norman E. ....Okemah
Jenkins, W. P. ....Okemah
Lucas, A. C. (F) (H) ....Castle
Melton. A. S. ....Okemah
Reynolds, Charles L. ....Weleetka
Spickard, L. J. ....Okemah
Whitney, M. L. ....Okemah

OKLAHOMA COUNTY

Abshier, A. Brooks ....1200 N. Walker, Okla. City
Adams. Robert H. ....515 N.W. 11th, Okla. City
Akin, Robert H. ....610 N.W. 9th, Okla. City
Albers, Donald D. ....301 N.W. 12th, Okla. City
Alford. J. M. (H) ....Medical Arts Bldg., Okla. City
Allen, George T. ....1200 N. Walker, Okla. City
Amspacher, James C. ....525 N.W. 11th, Okla. City
Anderson, Hubert M. ....525 N.W. 11th, Okla. City
Andrews, Leila E. (L) (F) ....509 N.W. 15th, Okla. City
Annadown, Ruth ....905 N.W. 95th, Okla. City
Anspaugh, Robert D. (M) ....U. S. Army Hospital, Fort Campbell, Kentucky
Appleton. M. M. ....610 N.W. 9th, Okla. City
Archer, Homer V. ....1220 N. Walker, Okla. City
Armstrong, Nolen L. ....2847 Wilshire, Okla. City
Avey, Harry Thompson, Jr. (M) ....Military Address Unknown
Baker, Marguerite M. ....1200 N.E. 63rd, Okla. City
Balyeat. Ray M. ....711 N.W. 10th, Okla. City
Bamforth, Betty Jane ....800 N.E. 13th, Okla. City
Barkett, N. F. V. ....Medical Arts Bldg., Okla. City
Barnes, Harry E. ....905 S.W. 29th, Okla. City
Barry, George N. ....525 N.W. 11th, Okla. City
Batchelor, John J. ....Medical Arts Bldg., Okla. City
Bates, C. E. ....VA Will Rogers Field, Okla. City
Bayley, Robert H.... ....800 N.E. 13, Okla. City
Baylor, Richard A. ....425 N.W. 12th, Okla. City
Bednar, Gerald, Jr. ....Medical Arts Bldg., Okla. City
Bell, Austin H. ....301 N.W. 12th, Okla. City
Bell, Joseph P. ....106½ Mid-America Blvd, Midwest City
Beller, Cleve ....1200 N. Walker, Okla. City
Bennett, Henry G., Jr. ....1111 N. Lee, Okla. City
Bennett. Howard A. ....801 N.E. 13th, Okla. City
Berry, Charles N. ....Medical Arts Bldg., Okla. City
Bielstein. C. M. ....301 N.W. 12th, Okla. City
Binder, Harold J. ....1220 N. Walker, Okla. City
Binkley, J. G. ....Municipal Bldg., Okla. City
Binkley, J. Samuel ....Medical Arts Bldg., Okla. City
Bird, Robert M. (AP) ....800 N.E. 13th, Okla. City
Blachly, Lucile S. ....605 N.W. 10th, Okla. City
Blair, Clifford J. ....1200 N. Walker, Okla. City
Blue, Johnny A. ....Hales Bldg., Okla. City
Boatright, Lloyd C. ....Cravens Bldg., Okla. City
Bodine, Charles ....1220 N. Walker, Okla. City
Bohan, Kenneth ....625½ N.W. 10th, Okla. City
Bolend, Rex ....VA Hospital, Jackson, Mississippi
Bondurant, C. P. ....Medical Arts Bldg., Okla. City
Bonham, William L. ....1111 N. Lee, Okla. City
Borecky, George L. ....521 N.W. 11th, Okla. City
Bozalis, George S. ....711 N.W. 10th, Okla. City
Bradford, Vance ....Medical Arts Bldg., Okla. City
Bradley, H. C. ....Cravens Bldg., Okla. City
Branham, Donald W. ....1200 N. Walker, Okla. City
Brewer, A. M. ....621 N.W. 10th, Okla. City
Brightwell, Richard J., Lt. Col. (M) ....APO 179, c/o PM, New York, New York
Brother, George M. ....Kirkwood,Missouri
Brown, C. Alton ....Home State Life Bldg., Okla. City
Brown, D. Nello ....510 N.W. 12th, Okla. City
Brown, Gerster W. ....Medical Arts Bldg., Okla. City
Brown, John Marion (M) ....APO, c/o PM, San Francisco, California
Buchner, Harold W. ....1323½ N. Robinson, Okla. City
Burke, Richard M. ....Medical Arts Bldg., Okla. City
Burton, John F. ....434 N.W. 13th, Okla. City
Butler, H. W. ....1200 N. Walker, Okla. City
Bynum, Turner ....510 N.W. 12th, Okla. City
Cailey, Leo F. (L) ....Rt. 1, Box 165, Okla. City
Campbell, Coyne H. ....Rt. 4, Box 65, Okla. City
Campbell, J. Moore, III Medical Arts Bldg., Okla. City
Cannon, J. M. ....210½ W. Commerce, Okla. City
Capps, J. F. ....Box 5573, Midwest City
Carpenter, R. E. ....413 N.W. 12 Okla. City
Casebeer, Robert L. (AP) ....400 N.W. 13th, Okla. City
Casper, Pete D. ....2909 Epperly Drive, Midwest City
Cates, Albert (H) ....2733 N.W. 20th, Okla. City
Caviness, J. J. ....Medical Arts Bldg., Okla. City
Charney, L. ....Medical Arts Bldg., Okla. City
Clark, LeMon ....Fayetteville, Arkansas
Clark, Ralph O. ....301 S.W. 23rd, Okla. City
Clay, Richard A. ....416 N.W. 13th, Okla. City
Clymer, Cyril E. ....Medical Arts Bldg., Okla. City
Clymer, John H. ....Medical Arts Bldg., Okla. City
Cochran, Bryce H. (AP) ....544 Atkinson Drive, Midwest City
Cochrane, Charles R. (M) ....Military Address Unknown
Coil, Jenner G. (M) ....A.P.O. 301, c/o PM, San Francisco, Calif.
Coley, A. J. (H) ....1929 N.W. Park Pl., Okla. City
Coley, Joe H. ....416 N.W. 13th, Okla. City
Collins, Glenn S. ....119 E. Atkinson Plaza Midwest City
Collins, Joe E. ....1325 S.W. 29th, Okla. City
Collins, Mabelle S. ....1325 S.W. 29th, Okla. City
Colvert, J. R. ....1319 Classen Drive, Okla. City
Conrad, Loyal L. ....800 N.E. 13th, Okla. City
Cook, C. E., Jr. ....1243 Britton Road, Okla. City
Cooke, Everette E. ....525 N.W. 11th, Okla. City
Cooper, F. Maxey ....Medical Arts Bldg., Okla. City
Coston, Tullos O. ....1111 N. Lee, Okla. City
Cotten, Daisy V. ....1111 N. Dewey, Okla. City
Courtright, Anne C. (AP) ....County Bldg., Okla. City
Coyle, John, J. Jr. ....1200 N. Walker, Okla. City
Coyner, Wallace R. ....Edmond
Crawford, Sterling T. ....1200 N. Walker, Okla. City
Crick, L. E. ....1417 N.W. 94th, Okla. City
Croom, William S. (AP) ....415 N.W. 12th, Okla. City
Cunningham, John A. ....First National Bank Bldg., Okla. City
Cushing, Vernon D. ....711 N.W. 10th, Okla. City
Daniel, John F. ....Medical Arts Bldg., Okla. City
Daniels, Harry A. ....610 N.W. 9th, Okla. City
Danstrom, John R. ....521 N.W. 11th, Okla. City
Dawson, Clarence B. ....1200 N. Walker, Okla. City
Delhotal, Charles E. (M) ....Alexandria Mun. Airport, Alexandria, La.
Dersch, Walter H., Sr. ....Medical Arts Bldg., Okla. City
Deupree, Harry L. ....1111 N. Lee, Okla. City
Dill, Francis E. ....Medical Arts Bldg., Okla. City
Dixon, Robert W. ....1449 Westwood, Okla. City
Dodson, Harrel C., Jr. ....800 N.E. 13th, Okla. City
Donnell, John J. ....525 N.W. 11th, Okla. City
Doudna, Hubert E. ....528 N.W. 12th, Okla. City

Dudley, Alberta Webb ....Box 30-W, Warr Acres Branch, Okla. City
Dunn, J. Hartwell (M) .....Sheppard A. F. B., Wichita Falls, Texas
Eastland, William E. .....Medical Arts Bldg., Okla. City
Edwards, Martin Dale .....4420 S.E. 28th, Okla. City
Edwards, Rheba L. .....4420 S.E. 28th, Okla. City
Eley, N. Price .....1319 Classen Drive, Okla. City
Eliel, Leonard P. .....825 N.E. 13th, Okla. City
Elliott, Arthur F. .....807 N.E. 23rd, Okla. City
Ellis, Leonard J., Jr. 4101 MacArthur Blvd., Okla. City
Emenhiser, Lee K. .....511 N.W. 11th, Okla. City
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Cannon, R. F. .....Miami
Carson, David .....Fairland
Chesnut, W. G. .....Miami
Connell, M. A. .....Picher
Cosby, Glen W. .....Miami
Detar, George A. .....Miami
Ford, Harry C. .....Miami
Graham, Rex M. .....Miami
Highland, J. E. .....Miami
Jacoby, J. S. .....Commerce
Kerr, Walter C. H. .....Picher
Letcher, C. W. .....Miami
McNanghton, G. P. .....Miami
Ralston, B. W. (L) (F) .....Commerce
Ritter, N. R. .....Picher
Rnssell, Richard .....Picher
Shelton, B. Wright .....Miami
Walker, C. F. (F) .....Grove
Wendelken, H. W. .....Miami
Wormington, F. L. (F) .....Miami

PAYNE COUNTY

Bassett, Clifford M. .....Cnshing
Davidson, W. N. .....Cnshing
Davidson, W. N., Jr. (AP) .....Cnshing
Eager, Ella L. .....Stillwater
Foshee, W. C. .....Stillwater
Freed, Leon C. .....Perkins
Fry, Powell E. .....Stillwater
Garnier, William H. .....Stillwater
Gathers, George B., Jr. (AP) .....Stillwater
Humphrey, D. W. .....Cushing
Martin, E. O. .....Cushing
Martin, James D. .....Cushing
Martin, John W. .....Cushing
Moore, Clifford W. .....Stillwater
Nelson, Harold G. .....Stillwater
Puckett, H. L. .....Stillwater
Reding, A. C. .....Stillwater
Rippy, O. M. .....Stillwater
Roberts, R. E. .....Stillwater
Sanders, Harold R. .....Stillwater
Smith, A. B. .....Stillwater
Smith, Haskell .....Stillwater
Thorp, Edward M. .....Cushing
Waggoner, R. E. .....Stillwater
Weber, Roxie A. .....Stillwater
Wilhite, L. R. .....Perkins

PAWNEE COUNTY

Haddox, C. H. .....Pawnee
Hargrove, Robert D. (AP) .....Pawnee
Judd, Loyd (AP) .....Pawnee

Lehew, J. L., Sr. (L) (F) ..... Pawnee
Saddoris, M. L. ..... Cleveland
Spaulding, H. B. ..... Ralston
Waters, C. B. ..... Pawnee

PITTSBURG COUNTY

Bartheld, Floyd T. ..... McAlester
Brown, George M., Jr. ..... McAlester
Coe, William O. ..... McAlester
Dakil, L. N. ..... McAlester
Dorrough, Joe ..... Haileyville
Ellis, H. A. (L) ..... Kiowa
Feamster, R. C. ..... Bellaire, Texas
Galbraith, Ben T. ..... McAlester
Greenberger, Edward D. ..... McAlester
Harkins, Richard A. ..... McAlester
Henry, M. L. ..... McAlester
Holland, C. K. ..... McAlester
Kaeiser, W. H. (M) ..... Ft. Benning, Ga.
Kuyrkendall, L. C. ..... McAlester
Lerblanc, William P., Jr. ..... Hartshorne
Lively, C. E. ..... McAlester
McCarley, T. H. ..... McAlester
Norman, S. L. ..... McAlester
Park, J. F. ..... McAlester
Rice, O. W. (L) (F) ..... McAlester
Shuller, E. H. ..... McAlester
Shuller, Thurman ..... McAlester
Stough, A. R. ..... McAlester
Wait, Will C. (L) ..... McAlester
Wheeler, H. C. ..... McAlester
Williams, C. O. (L) ..... McAlester
Willour, L. S. (F) (H) ..... McAlester
Wilson, Herbert A. ..... McAlester

PONTOTOC COUNTY

Bisbee, Rowe F. ..... Ada
Breco, Joseph G. (L) ..... Redondo Beach, California
Burns, S. L. (L) (F) ..... Stonewall
Cowling, Robert E. ..... Ada
Dean, W. F. ..... Ada
Deese, E. F. ..... Ada
Evans, Alden M. (AP) ..... Ada
Gill, W. T. ..... Ada
Gullatt, E. M. ..... Ada
Gwin, Jerry B. ..... Ada
Harrison, Stearley P. ..... Ada
Haugen, I. J. ..... Ada
Laurens, Henry, Jr. ..... Ada
McBride, Ollie ..... Ada
McKeel, Sam A. (F) (H) ..... Ada
Martin, Frank J. ..... Ada
Miller, Oscar H. ..... Ada
Morey, John B. ..... Ada
Muntz, Earl R. ..... Ada
Needham, C. F. ..... Ada
Northrip, Ray U. ..... Ada
Osborn, Carl D. ..... Ada
Padberg, E. D. ..... Ada
Peterson, William G. ..... Ada
Ramsay, David C. ..... Ada
Seaborn, T. L. (L) ..... Ada
Stephens, George K. ..... Ada
Sugg, Alfred R. ..... Ada
Taylor, Clarence P., Jr. (M) ..... Marine Div., c/o P.M. San Francisco, Calif.
Welborn, O. E. ..... Ada
Welborn, O. M. ..... Ada
Yagol, H. B. ..... Ada

POTTAWATOMIE COUNTY

Baxter, George S. ..... Shawnee
Baxter, Jack W. ..... Shawnee
Birdsong, Gordon G. ..... Brewster, Florida
Boggs, James T. (AP) ..... Shawnee
Campbell, Hiram G. (L) ..... Tecumseh
Carson, John M. ..... Shawnee
Combs, Leon D. (M) ..... U. S. Naval Hospital, Corona, Calif.
Davis, Francis A. ..... Shawnee
Dickinson, W. Paul (M) ..... c/o P.M., New York
Gallaher, Clinton ..... Shawnee
Gallaher, Paul ..... Shawnee
Gallaher, William M. (F) ..... Shawnee
Gauchat, August C. (AP) ..... Shawnee
Hayes, John R. ..... Shawnee
Henley, Billie Gene (AP) ..... Shawnee
Hirst, Claude M. ..... Shawnee
Hughes, Horton E. ..... Shawnee
Kayler, R. C. (F) ..... McLoud
Keen, Frank M. ..... Shawnee
Loudon, James D. ..... Shawnee
Lowenstein, Bernard (A) ..... New Mexico
McFarling, Alonza C. ..... Shawnee
Navin, Kenneth W. ..... Shawnee
Newlin, Frances P. ..... Shawnee
Paramore, Charles F. ..... Shawnee
Rice, E. Eugene ..... Shawnee
Wenger, Theodore R. (AP) ..... Tecumseh
Williams, Alpha McAdams ..... Shawnee
Worobec, Thomas (AP) ..... Shawnee
Young, C. C. ..... Shawnee

PUSHMATAHA COUNTY

Hampton, Hollis (M) ..... Military Address Unknown
Huckabay, B. M. ..... Antlers

ROGERS COUNTY

Anderson, Fred A. (L) ..... Claremore
Anderson, Paul S. ..... Claremore
Anderson, W. D. ..... Claremore
Gordon, Minor E. ..... Claremore
Howard, W. A. ..... Chelsea
Melinder, Roy J. ..... Claremore
Thomas, Denton B. ..... Chelsea

ROGER MILLS COUNTY

Buster, Frank ..... Cheyenne
(Member of Beckham County Society)
Cary, W. S. ..... Reydon
(Member of Beckham County Society)

SEMINOLE COUNTY

Austerman, Warrington ..... Konawa
Brown, Forest R. ..... Wewoka
Bunch, Allen H. ..... Seminole
Chambers, Claude S. ..... Seminole
Dakil, Samuel E. (AP) ..... Wewoka
Deaton, A. N. ..... Wewoka
Grimes, John P. ..... Wewoka
Hake, Oren J. (M) ..... Military Address Unknown
Harber, J. N. (H) ..... Phoenix, Arizona
Harrison, Gene H. ..... Seminole
Jones, W. E., Sr. ..... Seminole
Jones, W. E., Jr. ..... Seminole
Knight, Claude B. ..... Wewoka
McGovern, J. D. ..... Wewoka
Mosher, D. D. ..... Seminole
Price, J. T. ..... Seminole
Walker, Agnew A. ..... Wewoka
Wood, Jack A. ..... Seminole
Wood, Julian D. ..... Seminole

SEQUOYAH COUNTY

Morrow, John A. (H) (F) ..... Sallisaw

STEPHENS COUNTY

Brooks, J. T. ..... Duncan
Cheatwood, William R. ..... Duncan
Cunningham, John H. ..... Duncan
Davis, Randall E. ..... Duncan
Ellis, Richard A. ..... Duncan
Gregston, Jack L. ..... Marlow
Ivy, W. S. ..... Duncan
King, Everett G. (M) ..... 867 Arlington Ave., Berkeley, Calif.
Lindley, E. C. ..... Duncan

Lindley, E. H. ....Duncan
Patterson, F. L. ....Duncan
Patterson, Fred L., Jr. ....Duncan
Patterson, J. L. ....Duncan
Patterson, James, Jr. (M) ....c/o P.M. San Francisco, California
Spitzer, Lawrence L. ....Marlow
Talley, Charles N. ....Marlow
Thomasson, E. B. ....Duncan
Walker, W. K. ....Marlow
Weedn, A. J. ....Duncan
West, Glenn A. ....Duncan
Young, B. O. ....Duncan

TEXAS COUNTY

Blackmer, L. G. ....Hooker
Boggs, Nathan ....Goodwell
(Member of Oklahoma County Society)
Buford, E. L. ....Guymon
Cawley, Francis P. ....Hooker
Hayes, R. B. (L) ....Guymon
Hopkins, Glenn A. ....Guymon
Morgan, James E. ....Guymon
Smith, Morris ....Guymon

TILLMAN COUNTY

Bacon, O. G. ....Frederick
Comp, George A. (H) ....Manitou
Fisher, Roy L. ....Frederick
Fry, F. Polk ....Frederick
Fuqua, W. A. ....Grandfield
Short, L. O. ....Frederick
Tallant, George A. ....Frederick

TULSA COUNTY

Adams, George M. ....1419 E. 15th, Tulsa
Akins, Jack O. ....Medical Arts Bldg., Tulsa
Allen, Clifford W. ....Medical Arts Bldg., Tulsa
Andelman, Sumner Y. ....1611 S. Boston, Tulsa
Anderson, Robert L. ....Medical Arts Bldg., Tulsa
Armstrong, O. C. ....Medical Arts Bldg., Tulsa
Atchley, R. Q. ....Medical Arts Bldg., Tulsa
Atkins, Paul N., Sr. ....Medical Arts Bldg., Tulsa
Atkins, Paul N. Jr. ....Braniff Bldg., Tulsa
Bailey, Byron L. ....Medical Arts Bldg., Tulsa
Baker, Charles (J) ....1653 E. 12th St., Tulsa
Barham, J. H. ....Daniels Bldg., Tulsa
Barickman, R. I. ....915 S. Cin., Tulsa
Bartlett, F. L. (J) ....1923 S. Utica, Tulsa
Bate, Charles J. (AP) ....352½ N. Greenwood, Tulsa
Beddoe, Harold L. ....1345 E. 45th, Tulsa
Benton, Paul C. ....602 S. Cheyenne, Tulsa
Benzing, William M. ....Medical Arts Bldg., Tulsa
Berg, Milton Louis ....3505 S. Peoria, Tulsa
Berry, Spencer (J) ....1923 S. Utica, Tulsa
Black, Harold J. ....Medical Arts Bldg., Tulsa
Blocksom, Berget H. ....Medical Arts Bldg., Tulsa
Boone, W. B. ....4117 S. 26th W. Ave. Tulsa
Boyd, Hugh ....Braniff Bldg., Tulsa
Boyer, William F. ....604 S. Cin., Tulsa
Bradfield, Samuel J. ....Medical Arts Bldg., Tulsa
Brighton, Charles E. ....604 S. Cin., Tulsa
Brocksmith, Henry A. ....Court Arcade Building, Tulsa
Brogden, James C. ....Medical Arts Bldg., Tulsa
Brookshire, J. E. (H) ....Ritz Bldg., Tulsa
Brown, Manuel ....1619 E. 15th St., Tulsa
Brown, Paul R. (H) ....1614 E. 35th St., Tulsa
Brown, Walter E. ....2020 S. Xanthus, Tulsa
Brown, Henry S. ....Medical Arts Bldg., Tulsa
Brumfield, Thomas J. (AP) Medical Arts Bldg., Tulsa
Bryan, W. J., ...Medical Arts Bldg., Tulsa
Buchan, William H. (J) ....Braniff Bldg., Tulsa
Burns, Dixon N. ....Medical Arts Bldg., Tulsa
Caldwell, Charles L. ....115 E. 18th St., Tulsa
Calhoon, Edward (J) ....1653 E. 12th St., Tulsa
Calhoun, C. E. ....Sand Springs
Calhoun, W. H. ....Medical Arts Bldg., Tulsa
Capehart, John D. ....815 N. Osage Drive, Tulsa
Capehart, Maurice P. (J) ....Medical Arts Bldg., Tulsa
Carney, Andre B. ....915 S. Cin., Tulsa
Chalmers, J. S. ....Sand Springs
Charbonnet, P. N. (L) ....Box 41, Pass Christian, Mississippi
Chaves, Hector (J) ....1653 E. 12th St., Tulsa
Childers, Emil M. ....Stanolind Bldg., Tulsa
Childs, J. W. (L) ....Medical Arts Bldg., Tulsa
Clinton, Fred S. (H) ....230 E. Woodward Blvd., Tulsa
Clopton, James W. ....Durham, North Carolina
Cohen, Eugene S. ....1239 E. 36th Pl., Tulsa
Cohenour, Howard M. ....Medical Arts Bldg., Tulsa
Cook, W. Albert (H) (F) ....Medical Arts Bldg., Tulsa
Coulter, T. B. (L) ....Medical Arts Bldg., Tulsa
Covington, Terrell, Jr. ....Court Arcade Bldg., Tulsa
Craig, Paul E. ....Daniels Bldg., Tulsa
Crane, Donald V. ....Medical Arts Bldg., Tulsa
Crawford, William S. ....National Bank of Tulsa Bldg., Tulsa
Cronk, Gerald ....2020 South Xanthus, Tulsa
Dague, John C. ....Tri-State Insurance Bldg., Tulsa
Daily, R. E. ....Bixby
Davis, Arthur H. ....Medical Arts Bldg., Tulsa
Davis, George (J) ....1653 E. 12th St., Tulsa
Davis, George M., Sr. (L) ....Bixby
Davis, Thomas H. ....2020 S. Xanthus, Tulsa
Dean, W. A. ....Medical Arts Bldg., Tulsa
Denney, Lawrence A. ....Stanolind Bldg., Tulsa
Denser, John W. (AP) ....915 S. Cin., Tulsa
Dodd, Nevin W. ....1321 S. Main St., Tulsa
Donovan, Mark H. ....2120 E. 25th, Tulsa
Eads, Charles H. ....Medical Arts Bldg., Tulsa
Echols, Raymond S. ....1701 E. 19th, Tulsa
Edwards, David L. ....2020 S. Xanthus, Tulsa
Etherton, Monte C. ....10-A S. Lewis, Tulsa
Evans, Hugh J. ....Medical Arts Bldg., Tulsa
Ewell, William C. ....1307 S. Main, Tulsa
Farris, H. Lee (L) (F) ....2214 E. 25th St., Tulsa
Felman, E. F. (J) ....1923 S. Utica, Tulsa
Ferraro, Douglas T. ....1306 E. 35th St., Tulsa
First, Safety R. ....Medical Arts Bldg., Tulsa
Flack, F. L. ....McFarlin Bldg., Tulsa
Flanigan, H. F., Jr. ....Medical Arts Bldg., Tulsa
Ford, H. W. ....915 S. Cin., Tulsa
Forrest, Herbert J. ....1419 E. 15th Tulsa
Forry, Willis W. ....Bixby
Franklin, Onis ....Broken Arrow
Franklin, S. E. ....1619 E. 15th, Tulsa
French, Samuel L. ....Tri-State Insurance Bldg., Tulsa
Fulcher, Joseph ....1151 S. Peoria, Tulsa
Funk, Robert E. ....Medical Arts Bldg., Tulsa
Gaddis, John W. ....1530 S. Peoria, Tulsa
Gaddis, Newell C. ....1530 S. Peoria, Tulsa
Garrett, Claude (J) ....1653 E. 12th St., Tulsa
Garrett, D. L. ....Medical Arts Bldg., Tulsa
Gastineau, Felix T. ....Medical Arts Bldg., Tulsa
Geiger, William A. ....1321 S. Main, Tulsa
Gentry, E. Lee ....Medical Arts Bldg., Tulsa
Gilliland, Charles E. ....Kansas City, Missouri
Glass, Fred A. ....2020 S. Xanthus, Tulsa
Goddard, R. K., Sr. ....Skiatook
Goddard, Roy K., Jr. (AP) ....National Bank of Tulsa Bldg., Tulsa
Goen, Rayburne W. ....Braniff Bldg., Tulsa
Gomez, Francisco (J) ....1653 E. 12th St., Tulsa
Goodman, Samuel ....Medical Arts Bldg., Tulsa
Gorrell, Ben F. ....2257 E. 32nd, Tulsa
Gorrell, J. F. ....Medical Arts Bldg., Tulsa
Graham, Hugh C. ....1307 S. Main, Tulsa
Graham, Mary V. ....1306 E. 35th, Tulsa
Gray, John F., Jr. ....Medical Arts Bldg., Tulsa
Green, Harry ....Medical Arts Bldg., Tulsa
Grosshart, Paul L. ....Medical Arts Bldg., Tulsa
Grubb, Robert D. ....1306 E. 35th, Tulsa
Guild, Carl H., Jr. ....1419 E. 15th St., Tulsa
Hale, Arthur E. ....2020 S. Xanthus, Tulsa
Hall, C. H. (H) (F) ....15 W. Third, Tulsa
Haney, T. Paul ....521 S. Boulder, Tulsa
Haralson, Charles H. ....Medical Arts Bldg., Tulsa
Haralson, P. H. (J) ....1923 S. Utica, Tulsa
Hardman, T. J. ....Medical Arts Bldg., Tulsa

Harris, Bunn ..... Jenks
Hart, Mabel M. ..... 2529 S. Boston Pl., Tulsa
Hart, Marshall O. ..... 1228 S. Boulder, Tulsa
Harvey, Rosemary (J) ..... 1653 E. 12th St., Tulsa
Hayne, Robert A. ..... 604 S. Cin., Tulsa
Hays, Luvern ..... 2445 E. 27th Pl., Tulsa
Henderson, F. W. (L) ..... 1647 E. 1st., Tulsa
Henderson, William N. ..... 1415 E. 15th, Tulsa
Henley, Marvin D. ..... Medical Arts Bldg., Tulsa
Henry, Gifford H. ..... Court Arcade Bldg., Tulsa
Hill, O. L. ..... 915 S. Cin., Tulsa
Hinton, Robert (J) ..... 1653 E. 12th, Tulsa
Hoke, Clarence C. ..... Philtower Bldg., Tulsa
Hooper, J. S. (H) ..... Rt. 2, Rome, New York
Hoover, Wilkie D. ..... Stanolind Bldg., Tulsa
Hotz, Carl J. ..... 604 S. Cin., Tulsa
Huber, W. A. ..... Medical Arts Bldg., Tulsa
Hudson, David V. ..... 521 N. Boulder, Tulsa
Hudson, Margaret G. ..... 1759 South Victor, Tulsa
Humphrey, B. H. ..... Sperry
Hyatt, E. G. ..... 604 S. Cin., Tulsa
Ihrig, H. Kenneth ..... 1701 E. 19th, Tulsa
Jacobs, William S. ..... Court Arcade Bldg., Tulsa
Johnson, E. O. ..... Medical Arts Bldg., Tulsa
Johnson, Maxwell ..... Medical Arts Bldg., Tulsa
Johnson, Newman (J) ..... 1653 E. 12th St., Tulsa
Johnson, R. Chadwick (J) ..... Sand Springs
Johnson, R. R. (L) ..... Sand Springs
Johnson, Robert H. ..... 2020 S. Xanthus, Tulsa
Jones, Amy (J) ..... 1653 E. 12th St., Tulsa
Jones, Craig S. ..... 915 S. Cin., Tulsa
Kelley, James W. ..... Philtower Bldg., Tulsa
Kemmerly, H. P. ..... Medical Arts Bldg., Tulsa
Kerekes, Ernest S. ..... 1923 S. Utica, Tulsa
Ketchum, Hall (AP) ..... Medical Arts Bldg., Tulsa
Kishner, Leonard L. ..... 1619 E. 15th, Tulsa
Kornblee, A. T. ..... Medical Arts Bldg., Tulsa
Kramer, Allen C. ..... Medical Arts Bldg., Tulsa
Larrabee, W. S. ..... Medical Arts Bldg., Tulsa
Layton, O. E. ..... Collinsville
Ledbetter, Marion K. ..... 1453 S. Quaker, Tulsa
Lee, Judak K. ..... Court Arcade Bldg., Tulsa
Lee, Ottis S. ..... Springer Clinic, Tulsa
Leibovitz, Martin ..... Medical Arts Bldg., Tulsa
Lemaster, D. W. (L) ..... Route No. 1, Wayne
Lewis, Ceylon S. ..... Medical Arts Bldg., Tulsa
Lhevine, Dave B. ..... Medical Arts Bldg., Tulsa
Lhevine, Morris B. ..... Medical Arts Bldg., Tulsa
Lindstrom, W. Carl ..... Medical Arts Bldg., Tulsa
Loney, W. R. R. ..... Medical Arts Bldg., Tulsa
Lowbeer, Leo ..... 1653 E. 12th St., Tulsa
Lowe, J. O. ..... Thompson Bldg., Tulsa
Lubin, Emanuel Nathan ..... Medical Arts Bldg., Tulsa
Lucas, Boyd Vance ..... 2641 S. Columbia, Tulsa
Lusk, Earl M. ..... 915 S. Cin., Tulsa
Lynch, Thomas J. (L) ..... 2132 E. 24th, Tulsa
Lyons, Mason R. ..... Turley
MacDonald, Daniel M. ..... 1531 E. 15th, Tulsa
MacKenzie, Ian ..... Medical Arts Bldg., Tulsa
McCrary, Robert F. (AP) ..... Medical Arts Bldg., Tulsa
McDonald, John E. ..... Tri-State Insurance Bldg., Tulsa
McDowell, Richard E. ..... 222½ E. 5th, Tulsa
McDowell, Thomas A. (AP) ..... Medical Arts Bldg., Tulsa
McGill, Ralph A. ..... Medical Arts Bldg., Tulsa
McGraw, W. L. ..... 1330 S. Lewis, Tulsa
Margolin, Berthe ..... 2739 E. 22nd St., Tulsa
Markland, James D. ..... Medical Arts Bldg., Tulsa
Martin, Ralph F. ..... Sand Springs
Matt, John G. ..... Medical Arts Bldg., Tulsa
Mayginnes, P. H. (H) (F) ..... 1624 S. Norfolk, Tulsa
Mays, W. G. (J) ..... 1923 S. Utica, Tulsa
Mery, Albert M. ..... Braniff Bldg., Tulsa
Miller, Elnora G. ..... McBirney Bldg., Tulsa
Miller, George H. ..... Atlas Life Bldg., Tulsa
Mishler, Donald L. ..... 604 S. Cin., Tulsa
Mitchell, Tom Hall ..... National Bank of Tulsa Bldg., Tulsa
Mohrman,, Silas S. (L) ..... 1818 E. 15th, Tulsa
Moore, Edward L. ..... Braniff Bldg., Tulsa
Moore, Matthew B. ..... Braniff Bldg., Tulsa
Morgan, Carl C. ..... 1701 E. 19th, Tulsa
Mulmed, Earl I ..... Braniff Bldg., Tulsa
Munding, L. A. ..... Medical Arts Bldg., Tulsa
Murdock, H. D. ..... Medical Arts Bldg., Tulsa
Murray, Silas (L) ..... Medical Arts Bldg., Tulsa
Nathan, Robert E. ..... Medical Arts Bldg., Tulsa
Neal, James H. ..... 521 N. Boulder, Tulsa
Neal, James H., Jr. ..... 915 S. Cin., Tulsa
Nelson, F. L. ..... 2303 E. 3rd, Tulsa
Nelson, Frank J. ..... 2020 S. Xanthus, Tulsa
Nelson, Iron H. ..... Medical Arts Bldg., Tulsa
Nelson, M. O. ..... Medical Arts Bldg., Tulsa
Nesbitt, P. P. (H) ..... 1565 Swan Drive, Tulsa
Newlin, W. H. ..... Broken Arrow
Nicholas, Hugh B. ..... 1918 N. Oxford, Tulsa
Northrup, L. C. ..... 1307 S. Main, Tulsa
O'Meilia, W. J. ..... Braniff Bldg., Tulsa
Orr, Herbert ..... 1645 E. 15th, Tulsa
Palik, Emil E. ..... 1923 S. Utica, Tulsa
Park, Felix R. ..... Medical Arts Bldg., Tulsa
Parmenter, D. C. ..... 1204 S. Cheyenne, Tulsa
Pascucci, Lucien ..... 1923 S. Utica, Tulsa
Pavy, C. A. ..... Medical Arts Bldg., Tulsa
Peden, James C. ..... Medical Arts Bldg., Tulsa
Perry, Daniel (L) ..... 222 E. 5th, Tulsa
Perry, Fred J. ..... Braniff Bldg., Tulsa
Perry, Hugh ..... 222 E. 5th, Tulsa
Perry, John C. ..... Medical Arts Bldg., Tulsa
Peters, James C. ..... 915 S. Cin., Tulsa
Pigford, R. C. (L) ..... 2427 E. 26th St., Tulsa
Pollack, Simon ..... Braniff Bldg., Tulsa
Porter, Horace H. ..... 1419 E. 15th St., Tulsa
Pratt, William C. ..... 604 S. Cin., Tulsa
Presson, L. C. (L) ..... 1948 N. Main, Tulsa
Ray, R. G. ..... 3015 E. 15th St., Tulsa
Reese, K. C. ..... Medical Arts Bldg., Tulsa
Reynolds, Ernest W. ..... 1307 S. Main, Tulsa
Reynolds, James L. (H) ..... 1516 N. Cin., Tulsa
Rhodes, R. E. L. (L) ..... 2220 S. St. Louis, Tulsa
Richardson, Jack L. ..... 19 West 10th St., Tulsa
Richey, S. M. (H) ..... Address Unknown
Riley, N. C. ..... 608 S. Cin., Tulsa
Roberts, T. R. ..... Wright Bldg., Tulsa
Rogers, James W. ..... Medical Arts Bldg., Tulsa
Rubin, H. J. ..... 1619 E. 15th St., Tulsa
Ruprecht, H. A. ..... 604 S. Cin., Tulsa
Russell, G. R. ..... 604 S. Cin., Tulsa
Salamy, Joseph ..... 2523 E. 11th St., Tulsa
Sanger, W. B. ..... Medical Arts Bldg., Tulsa
Schneider, Edward M. ..... 1101 E. 15th, Tulsa
Schreck, Philip M. ..... Medical Arts Bldg., Tulsa
Searle, Maurice J. ..... Medical Arts Bldg., Tulsa
Sethney, Walter F. ..... 2828 E. 15th, Tulsa
Shackelford, Paul (J) ..... Stony Brook, New York
Shapiro, David ..... 1101 E. 15th, Tulsa
Shepard, Robert M., Jr., ... Medical Arts Bldg., Tulsa
Shepard, R. M. ..... Medical Arts Bldg., Tulsa
Shepard, S. C. ..... Medical Arts Bldg., Tulsa
Sherwood, R. G. ..... Court Arcade Bldg., Tulsa
Shipp, J. D. ..... Medical Arts Bldg., Tulsa
Showman, W. A. ..... Medical Arts Bldg., Tulsa
Simpson, Carl F. ..... Medical Arts Bldg., Tulsa
Simpson, J. D. (J) ..... 1923 S. Utica, Tulsa
Sinclair, F. D. ..... Medical Arts Bldg., Tulsa
Sippel, Mary Edna ..... 1544 E. 15th, Tulsa
Sisler, Wade ..... 807 S. Elgin, Tulsa
Smith, D. O. ..... 604 S. Cin., Tulsa
Smith, Rurie N. ..... Medical Arts Bldg., Tulsa
Smith, Wendel L. ..... 2431 E. Admiral, Tulsa
Smith, William O. ..... Tri-State Insurance Bldg., Tulsa
Spann, Joe L. ..... Braniff Bldg., Tulsa
Spann, Logan A. ..... Braniff Bldg., Tulsa
Springer, M. P. ..... 118 E. 6th, Tulsa
Stallings, T. W. (L) ..... 724 S. Elgin, Tulsa
Stanley, M. V. ..... 1632 E. 15th, Tulsa
Steel, Marcella R. ..... 604 S. Cin., Tulsa
Stevenson, James ..... Medical Arts Bldg., Tulsa
Stewart, H. B. ..... 1701 E. 19th, Tulsa
Stokes, E. Malcolm (M) 2500 Med. Grp. Mitchell A.F.B. New York

Stokes, Lowell ..... 1321 S. Main, Tulsa
Stowell, Averill ..... 604 S. Cin., Tulsa
Strong, Paul T. ..... 2020 S. Xanthus, Tulsa
Stuard, C. G. ..... Court Arcade Bldg., Tulsa
Stuart, Frank A. ..... Tri-State Insurance Bldg., Tulsa
Stuart, Leon H. ..... Medical Arts Bldg., Tulsa
Stuart, Royal E. ..... Braniff Bldg., Tulsa
Summers, C. S. ..... Dauiels Bldg., Tulsa
Sundgren, Vincel ..... 604 S. Cin., Tulsa
Swanson, K. F. ..... 604 S. Cin., Tulsa
Thomas, Harlan ..... Medical Arts Bldg., Tulsa
Thomas, William F., Jr. ..... Braniff Bldg., Tulsa
Thompson, James B. ..... Medical Arts Bldg., Tulsa
Thompson, Oliver H. ..... Court Arcade Bldg., Tulsa
Trainor, W. J. ..... Medical Arts Bldg., Tulsa
Turnbow, W. R. ..... 3015 E. 15th St., Tulsa
Turnbull, Theodore G. ..... 222 E. 5th St., Tulsa
Turner, Thomas R. ..... 604 S. Cin., Tulsa
Tyler, Joe E. ..... 604 S. Cin., Tulsa
Underwood, David J. ..... Medical Arts Bldg., Tulsa
Underwood, F. L. ..... Medical Arts Bldg., Tulsa
Ungerman, A. H. ..... Medical Arts Bldg., Tulsa
Ungerman, Milford S. ..... Medical Arts Bldg., Tulsa
Vammen, Adolph N. (AP) ..... 1415 E. 15th, Tulsa
Venable, Sidney C. (L) ..... 1757 S. Columbia, Tulsa
Wadsworth, R. M. ..... 1445 S. Quaker, Tulsa
Walker, Dean C. ..... 604 S. Cin., Tulsa
Walker, W. A. ..... 1215 S. Utica, Tulsa
Wallace, Albert W. ..... 604 S. Cin., Tulsa
Wallace, J. E. (L) ..... 1328 S. Peoria, Tulsa
Ward, Benjamin W. ..... 1916 S. Utica, Tulsa
Weinberg, Harry B. (AP) ..... 1101 E. 15th, Tulsa
White, Eric M. ..... Medical Arts Bldg., Tulsa
White, Harold A. ..... Medical Arts Bldg., Tulsa
White, James W. ..... 1515 S. Boston, Tulsa
White, N. S. ..... Medical Arts Bldg., Tulsa
Wilbanks, Charles E. ..... 717 N. Lewis, Tulsa
Wiley, A. Ray ..... Medical Arts Bldg., Tulsa
Williams, Theo S. ..... Medical Arts Bldg., Tulsa
Wilner, Sol ..... Medical Arts Bldg., Tulsa
Witcher, Robert B. ..... Medical Arts Bldg., Tulsa
Wolff, Eugene G. ..... 1701 E. 19th, Tulsa
Woodson, Fred E. ..... Medical Arts Bldg., Tulsa
Wright, Keuneth L., Jr. (M) Military Address Unknown
Yandell, Hays R. ..... 2020 S. Xanthus, Tulsa

WAGONER COUNTY

Divine, Duke G. ..... Wagoner
Jones, Edward A. (M) ..... Newport, R. I.
Riddle, H. K. ..... Coweta
Tuttle, Howard D. (AP) ..... Wagoner
Varian, Thelma S. ..... Wagoner

WASHINGTON COUNTY

Aldredge, William M. ..... Bartlesville
Athey, J. V. (L) (F) ..... Bartlesville
Beechwood, E. E. ..... Bartlesville
Bogan, Robert J. ..... Bartlesville
Chamberlain, Elizabeth (L) ..... Bartlesville
Davis, K. D. ..... Bartlesville
Denyer, H. E. ..... Bartlesville
Etter, F. S. ..... Bartlesville
Gentry, R. C. ..... Bartlesville
Green, O. I. ..... Bartlesville
Hudson, L. D. ..... Dewey
Huntington, Camp S. ..... Bartlesville
Johnson, C. L., Jr. ..... Bartlesville
Kingman, W. H. (H) ..... Bartlesville
Lawrence, Forrest C. ..... Bartlesville
Leblanc, William (L) (F) ..... Ochelata
Lindsay, Joseph H. (AP) ..... Dewey
Lockard, Vern (AP) ..... Bartlesville
Pittman, Cole D. ..... Bartlesville
Rewerts, F. C. ..... Bartlesville
Shipman, W. H. (H) ..... Bartlesville
Smith, Joseph G. (L) ..... Bartlesville
Somerville, O. S. (L) (F) ..... Bartlesville
Staver, B. F. ..... Bartlesville
Torrey, J. P. (L) ..... Bartlesville
Tulloch, George M. ..... Bartlesville
Vansant, J. P. ..... Dewey
Wells, Thomas J. ..... Bartlesville
Word, Lee B. ..... Bartlesville

WASHITA COUNTY

Anderson, Roy W. ..... Cordell
Bungardt, A. H. (F) ..... Cordell
Jones, John Paul (H) (F) ..... Dill
Livingston, L. G. ..... Cordell
Stowers, Aubrey E. ..... Sentinel

WOODWARD COUNTY

Braly, M. K. ..... Woodward
Camp, Ray J. ..... Woodward
Cobb, N. E. ..... Mooreland
Day, John L. (L) ..... Woodward
Duer, Joe L. ..... Woodward
England, Myron C. ..... Woodward
Fetzer, Jack D. ..... Woodward
Flack, Frank E. ..... Woodward
Johnson, H. L. ..... Fort Supply
Leachman, T. C. (L) (F) ..... 3512 Stuart, Ave., Richmond, Va.
Merrifield, F. R., Jr. ..... Mooreland
Obermiller, R. G. ..... Woodward
Pierson, O. A. ..... Woodward
Snow, Otis ..... Fort Supply
Tedrowe, C. W. (F) ..... Woodward
Triplett, T. Burke ..... Mooreland
Vloedman, D. A. (AP) ..... Woodward
Williams, C. E. ..... Woodward

WOODS COUNTY

Ensor, D. B. ..... Hopeton
Grantham, Elizabeth (H) ..... Alva
La Fon, W. F. ..... Alva
Monfort, Mariam F. (AP) ..... Alva
Peacher, Kenneth L. ..... Waynoka
Simon, John F. ..... Alva
Stephenson, I. F. ..... Alva
Templin, O. E. (L) ..... Alva
Traverse, C. A. ..... Alva
Whiteneck, Rhonald A. ..... Waynoka

OKLAHOMA STATE MEDICAL ASSOCIATION

1227 Classen Drive — Oklahoma City, Oklahoma

Telephone REgent 9-1648

OFFICERS 1952-1953

PRESIDENT

ALFRED R. SUGG, M.D. ..... Ada, Oklahoma

PRESIDENT-ELECT

JOHN E. McDONALD, M.D. ..... Tulsa, Oklahoma

VICE-PRESIDENT

JAMES R. PETTY, M.D. ..... Guthrie, Oklahoma

SECRETARY-TREASURER

LEWIS J. MOORMAN, M.D. ..... Oklahoma City, Oklahoma

DELEGATES TO AMERICAN MEDICAL ASSOCIATION

JAMES STEVENSON, M.D. ..... Tulsa, Oklahoma
JOHN F. BURTON, M.D. ..... Oklahoma City, Oklahoma

ALTERNATE DELEGATES TO AMERICAN MEDICAL ASSOCIATION

NED BURLESON, M.D. ..... Prague, Oklahoma
MALCOM PHELPS, M.D. ..... El Reno, Oklahoma

SPEAKER OF THE HOUSE OF DELEGATES

CLINTON GALLAHER, M.D. ..... Shawnee, Oklahoma

VICE-SPEAKER OF THE HOUSE OF DELEGATES

KEILLER HAYNIE, M.D. ..... Durant, Oklahoma

Executive Secretary
DICK GRAHAM

Associate Executive Secretary
JOHN K. HART

GENERAL COUNSEL

KEATON-WELLS-JOHNSTON AND LYTLE
Commerce Exchange Building — Oklahoma City, Oklahoma

COUNCIL

District No. 1: Craig, Delaware, Mayes, Nowata, Ottawa, Rogers, Washington.

Councilor (1953) ..... F. S. Etter, M.D., Bartlesville
Vice-Councilor (1953) ..... J. E. Highland, M.D., Miami

District No. 2: Kay, Noble, Osage, Pawnee, Payne.

Councilor (1954) ..... Clifford Bassett, M.D., Cushing
Vice-Councilor (1954) ..... E. C. Mohler, M.D., Ponca City

District No. 3: Garfield, Grant, Kingfisher, Logan.

Councilor (1955) ..... Bruce Hinson, M.D., Enid
Vice-Councilor (1955) ..... C. M. Hodgson, M.D., Kingfisher

District No. 4: Alfalfa, Beaver, Cimarron, Ellis, Harper, Major, Texas, Woods, Woodward.

Councilor (1953) ..... O. C. Newman, M.D., Shattuck
Vice-Councilor (1953) ..... L. R. Kirby, M.D., Cherokee

District No. 5: Beckham, Blaine, Canadian, Custer, Dewey, Roger Mills.

Councilor (1954) ..... A. L. Johnson, M.D., El Reno
Vice-Councilor (1954) ..... Ross Deputy, M.D., Clinton

District No. 6: Oklahoma

Councilor (1955) ..... R. Q. Goodwin, M.D., Oklahoma City
Vice-Councilor (1955) ..... Allen Gibbs, M.D., Oklahoma City

District No. 7: Cleveland, Creek, Lincoln, Okfuskee, Pottawatomie, Seminole.

Councilor (1953) ..... W. T. Mayfield, M.D., Norman
Vice-Councilor (1953) ..... Paul Gallaher, M.D., Shawnee

District No. 8: Tulsa.

Councilor (1954) ..... Wilkie Hoover, M.D., Tulsa
Vice-Councilor (1954) ..... W. A. Showman, M.D., Tuls

District No. 9: Adair, Cherokee, McIntosh, Muskogee, Okmulgee, Sequoyah, Wagoner.

Councilor (1955) ..... F. R. First, Jr., M.D., Checotah
Vice-Councilor (1955) ..... I. W. Bollinger, M.D., Henryetta

District No. 10: Haskell, Hughes, Latimer, LeFlore, Pittsburg.

Councilor (1953) ..... E. H. Shuller, M.D., McAlester
Vice-Councilor (1953) ..... Paul Kernek, M.D., Holdenville

District No. 11: Atoka, Bryan, Choctaw, Coal, McCurtain, Pushmataha.

Councilor (1954) ..... A. T. Baker, M.M., Durant
Vice Councilor (1954) ..... T. E. Rhea, M.D., Idabel

District No. 12: Carter, Garvin, Johnston, Love, Marshall, McClain, Murray, Pontotoc.

Councilor (1955) ..... J. H. Veazey, M.D., Ardmore
Vice-Councilor (1955) ..... W. T. Gill, M.D., Ada

District No. 13: Caddo, Comanche, Cotton, Grady, Jefferson, Stephens.

Councilor (1955) ..... H. M. McClure, M.D., Chickasha
Vice-Councilor (1955) ..... J. B. Miles, M.D., Anadarko

District No. 14: Greer, Harmon, Jackson, Kiowa, Tillman, Washita.

Councilor (1954) ..... L. G. Livingston, M.D., Cordell
Vice-Councilor (1954) ..... J. B. Hollis, M.D., Mangum

OKLAHOMA STATE MEDICAL ASSOCIATION
CONSTITUTION AND BY-LAWS

CONSTITUTION

ARTICLE I
Title

The name of this organization is the OKLAHOMA STATE MEDICAL ASSOCIATION, INCORPORATED.

ARTICLE II
Purpose of the Association

This Association is formed to promote the science and art of medicine.

ARTICLE III
Component Societies

The membership of the Association shall be organized into county medical societies and/or district medical societies, as circumstances may direct and as the Association may determine. The name and function of each society and its relations to the Association shall be defined in a charter issued by the Association, subject to amendment and revocation by the Association in accordance with such terms as may be prescribed in the By-Laws of the Association.

ARTICLE IV
Membership

Membership in this Association shall be considered a privilege and not a right. The membership of this Association shall be comprised of all members in good standing of its component societies as indicated by the membership records of the Association.

ARTICLE V
House of Delegates

Section 1. The House of Delegates shall be composed of: (1) Delegates elected by the component county and/or district societies of the Association, (2) The officers of the Association enumerated in ARTICLE VIII, Section 1, of this Constitution, and (3) The Oklahoma Delegates to the American Medical Association.

Section 2. All legislative powers of the Association reside in the House of Delegates which alone shall have authority to determine the policies of the Association. The House of Delegates shall transact all business of the Association, directly or through agencies or agents created by it, the transaction of which is not vested by this Constitution in any other agency. The House of Delegates shall elect the general officers of the Association.

Section 3. The House of Delegates shall provide for a division of the scientific work of the Association into such sections or departments as, in the judgment of the House, will best promote the scientific and professional activities of the Association.

Section 4. The House of Delegates may provide for the organization of such Councilor District Societies as, in its judgment, will promote the best interests of the profession, but the membership of any such society shall be limited to members of the component county societies of which it is made up.

Section 5. The House of Delegates shall divide the state into Councilor Districts specifying which county or counties shall be in each district.

ARTICLE VI
The Council

Section 1. The Council shall consist of one Councilor elected from each Councilor District, the President, President-Elect, Secretary-Treasurer and Speaker of the House of Delegates of the Association.

Section 2. The Council shall be the Executive Board of this Association and shall carry out the mandates and policies of the Association which are determined by the House of Delegates. The Council shall have supervision and control of the finances and particularly the expenditures of the Association, the investment of its funds and the direction and control of its property.

Section 3. The Council shall meet at least once during the annual session, and on call by the President between annual sessions of the Association on his own initiative or by petition to the President by at least one-third of the members of the Council.

ARTICLE VII
Sessions and Meetings

Section 1. The Association shall hold an annual session at such a place as shall be determined by the House of Delegates. For good and sufficient reason, the annual meeting place may be changed by a three-fourths vote of the Council.

Section 2. During the annual session there shall be held (1) at least one general meeting open to all registered members and guests, (2) at least one meeting of the House of Delegates, and (3) at least one meeting of the Council.

Section 3. The Council, by a vote of two-thirds of its entire membership may call a special meeting of the House of Delegates, and upon petition by thirty (30) or more delegates, the speaker of the House of Delegates or the President of the Association shall call such a meeting. At any such meeting, no business shall be transacted except that specified in the call.

ARTICLE VIII
General Officers

Section 1. The general officers of the Association shall be President, President-Elect, Vice President, Secretary-Treasurer, Speaker and Vice-Speaker of the House of Delegates, and the number of Councilors and Vice-Councilors as fixed by the House of Delegatees.

Section 2. The President-Elect and Vice President shall be elected for a term of one year; the Secretary-Treasurer, Speaker of the House of Delegates and Vice-Speaker of the House of Delegates for two years; and the Councilors and Vice-Councilors for three years, the Councilors being divided into classes so that approximately one-third of the Councilors shall be elected each year. The President-Elect shall become President for a term of one year upon the expiration of his term as President-Elect.

Section 3. All of the above officers shall assume the duties of their respective offices immediately upon the close of the annual session at which they were elected to serve and shall serve until their successors have been elected and installed.

Section 4. Vacancies created by the death, resignation or removal of the above named officers shall be filled by temporary appointment by the President being effective until the next annual meeting of the House of Delegates which shall elect a successor to complete the unexpired term, if any, except the President, whose place shall be filled by the Vice-President, and the Speaker of the House of Delegates, whose unexpired term shall be filled by the Vice-Speaker and Councilors, whose terms shall be completed by their respective Vice-Councilors.

ARTICLE IX
Finances

Section 1. Funds for conducting the affairs of the Association may be raised (1) by such special assessments on and/or annual dues from members of this

Association as the House of Delegates determines advisable, provided that such assessments and dues, with respect to its members, shall be collected by each component county and/or district society and forwarded by its secretary to this Association, (2) by voluntary contributions requested by resolution, and (3) in any other manner approved by the House of Delegates.

Section 2. The Council shall, at the annual session submit a budget to the House of Delegates for its approval, detailing the financial needs of the Association for the ensuing year. The House of Delegates, if it approves the budget, shall make such appropriations as are called for therein.

ARTICLE X
Referendum

Section 1. At any session of the House of Delegates, the House may, by a two-thirds vote of its registered members, submit any question to the membership of the Association for its vote. A majority vote of all the members of the Association shall determine the question.

Section 2. The Council shall be in charge of the referendum and may designate an officer of the Association or a Committee to canvass the vote and announce the results.

ARTICLE XI
Seal

The Association shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

ARTICLE XII
Ethics

The Principles of Medical Ethics of the American Medical Association in force at the time of the adoption of this Constitution, and as they may from time to time thereafter be amended by the American Medical Association, shall be accepted as the Principles of Medical Ethics of the Oklahoma State Medical Association and shall be binding on its members and on its component county and/or district societies.

ARTICLE XIII
Amendments

The House of Delegates may amend any article of this Constitution or any section or part thereof by a two-thirds vote of the Delegates registered at any Annual Session, provided that copies of the proposed amendment be sent with notices to the various component societies at least sixty (60) days before the Annual Meeting, and that the proposed amendments be published at least once during the year in the Journal, and that no such amendments become effective until the close of the Annual Session.

ARTICLE XIV

This Constitution supersedes and repeals all previous Constitutions. All By-Laws, resolutions and enactments in conflict herewith are declared to be of no effect.

(Constitution Adoped 1940)
(As Amended Through 1952)

BY-LAWS

CHAPTER I—Membership

Section 1. Eligibility

All members in good standing of the component societies of this Association, as indicated by the membership records of this Association, are members of this Association. However, a component society shall admit to membership only such a person as is a citizen of the United States, possesses the degree of Doctor of Medicine or a foreign degree in medicine regarded by the Council of the Association as equivalent thereto and in addition, has been licensed to practice medicine and surgery by the Oklahoma State Board of Medical Examiners, and whose Federal narcotics permit has not been revoked nor surrendered nor the issuance of such a permit denied, because of proved violations of State or Federal narcotics laws, provided, however, that any Doctor of Medicine whose narcotics permit has been revoked or surrendered or the issuance thereof denied may make application for membership when such narcotics permit has been reissued for a year or more at the time of such application.

(a) Any physician who is associated with the Armed Forces, Veterans Administration, or the United States Public Health Service and who does not possess a license to practice medicine in the State of Oklahoma but who otherwise meets the qualifications for membership may be elected to membership by a County Medical Society, but may not hold office or be a member of the House of Delegates.

Section 2. Rights

(a) Only members of this Association who are in good standing will be entitled to any of the rights, benefits and privileges of the Association, including the right to register at the annual session of the Association. The presence of a physician's name on the official roster of the Association, after it has been properly reported to the Executive Secretary of this Association by the Secretary of his county and/or district society, shall be prima facie evidence of membership, good standing, and the right to register at an annual session. No member shall take part in any of the proceedings of the annual session until he has registered.

(b) All members of the component county and/or district societies, in good standing and whose dues and assessments in this Association and the American Medical Association have been received from their component societies, are active members. Only active members are entitled to hold an office in this Association.

(c) Each Councilor District shall have one Councilor and one Vice-Councilor, however, only one vote in the Council will be apportioned to each Councilor District. The Vice-Councilor may vote in the absence of the Councilor without a proxy from the Councilor.

Section 3. Classification

Members of this Association shall be divided into the following classes: active members, life members, honorary members, junior members, associate members, and special service members.

(a) Active Members

Active members shall include all eligible members of component county and/or district societies, providing that their dues and assessments in this Association have been received from component societies.

(b) Honorary Members

Any physician, a member of this Association, who by reason of ill health or age shall retire from the active practice of medicine, or who has been engaged in the active practice of medicine fifty years, or more and whose service to humanity and his profession has been so unusually outstanding as to merit honorary recognition may be placed on the Honorary Membership roll. Eligibility for such consideration is limited to those physicians who have been members of this Association not less than five years immediately preceding application and whose petition for such membership is initiated by a component society of this Association, presented for consideration to the Executive Secretary not less than three mouths before the next annual session and whose names shall have been published iu the Journal issued immediately preceding the annual session. Provided, however, that any former member of the Association, who, at the time his membership lapsed, had been an active member of the Association for five (5) years and who possesses the other qualifications for Honorary Membership, shall be eligible for election to Honorary Membership on presentation of his peti-

tion by the component society of the county in which he resides, if the petition for such physician is presented to the Executive Secretary before January 1, 1952. After the 1952 Annual Session, Honorary Membership shall not be available under the terms of this proviso.

The approval of the House of Delegates, by a majority vote thereof at the annual session, shall be necessary to place such eligible members on the Honorary Membership roll. Such members shall have all the privileges of active membership except holding office, and shall not be required to pay dues or assessments in this Association. Honorary Members shall be considered the same as fully-paid members in computiug the membership of the County Societies for the purpose of determining the number of Delegates that the County Societies shall be entitled to send to the House of Delegates as provided by these By-Laws.

(c) Life Members

Any physician, a member of this Association who by reason of ill health or age shall retire from the active practice of medicine and who the County Society believes does not fall in the category to be considered as an Honorary Member (or who is, in the judgment of his County Medical Society, impaired by reason of physical disability or age from conducting a sufficiently active practice to pay dues and assessments, without undue hardship, or who has been engaged in the active practice of medicine fifty years, or more) may be placed on the Life Membership roll. Eligibility for such consideration is limited to those physicians who have been members of this Association for not less than the preceding five years and whose petition for such membership is initiated by a component society of this Association, presented for consideration to the Executive Secretary not less than three months before the next annual session and whose names shall have been published in the Journal issued immediately preceding the annual session. Provided, however, that any former member of the Association, who at the time his membership lapsed, had been an active member of the Associatiou for five (5) years, and who possesses the other qualifications for Life Membership, shall be eligible for election to Life Membership on presentation of his petition by the componeut society of the county in which he resides, if the petition for such physiciau is presented to the Executive Secretary before January 1, 1952. After the 1952 Anuual Session, Life Membership shall not be available under the terms of this proviso.

The approval of the House of Delegates, by a majority vote thereof at the annual session, shall be necessary to place such eligible members on the Life Membership roll. Such members shall have all the privileges of active membership except holding office, aud shall not be required to pay dues or assessments in this Association. Life Members shall be considered the same as fully-paid members in computing the membership of the Couuty Societies for the purpose of determining the number of Delegates that the County Societies shall be entitled to send to the House of Delegattes as provided in these By-Laws.

(d) Junior Members

Physiciaus serving as interns or residents on full time shall be entitled to Junior Membership in the component county and/or district societies, and in this Association. No dues shall be assessed such members and they shall be entitled to all privileges of membership except holding office. Privilege of holding Junior Membership in this Association shall be limited to the period of hospital training. Such memberships shall not be considered in the computation of the number of delegates to which a component society is entitled.

(e) Associate Members

The House of Delegates may elect to Associate Membership any person who cannot qualify for either Active, Life, Honorary or Junior Membership, if in the majority opinion of the House of Delegates, his contributions to medicine or the Association justifies the conferring of such an honor. Any County Society may place before the House of Delegates petitions for Associate Membership, after having first submitted the petition to the Council at least ninety (90) days before the Annual Meeting and receiving Council approval of the petitiou.

Petitions for Associate Membership may also originate in the Council, however, in all instances, all petitions for Associate Membership must be published in the issue of the Journal published at least thirty (30) days before the Annual Meeting.

(f) Special Service Members

Any physician who is in the Armed Forces of the United States, who has been licensed to practice medicine and surgery in Oklahoma, and who has not previously been a member of any county medical society may be recoguized as a Special Service Member by this Association. Such physician shall first have been elected to membership as a Special Service Member by a component county society in accordance with the provisions of its Constitution and By-Laws, and the fact of such membership certified to the Executive Secretary of the Association. Special Service membership shall include all rights and privileges of Active Membership except voting and holding office.

No dues shall be assessed such member until the month following his discharge from the Armed Forces of the United States and at which time he shall pay prorated dues for the balance of the year following his discharge from active service. Special Service membership shall lapse at the close of the calendar year following the discharge of each such member from service with the Armed Forces.

Sectiou 4. Membership Requirements

(a) Good Staudiug

A member who is uuder sentence of suspension or expulsion from any componeut society of this Association, or whose name has been dropped from its roll of members, whether as a result of disciplinary action or because of failure to pay dues, is not a member in good standing, within the meaning of this Chapter. This is true even though the defeudant or expelled member or the member whose uame has been dropped, has appealed to the Council of the Oklahoma State Medical Association for a review of such action, and his appeal has not yet been acted upon.

(b) Removal From Rolls

The membership in the Oklahoma State Medical Association and any component society of any member whose Federal narcotics permit has been revoked or surreudered because of proved violations of State or Federal narcotics laws shall be automatically terminated, and his name dropped from the membership rolls as of the effective date of such revocatiou or surreuder.

Section 5. Revocation of Honorary, Associate and Life Membership

Any Houorary, Associate or Life Membership may be revoked by a two-thirds vote of the House of Delegates when, in the opinion of the House of Delegates, the conduct or actions of the Honorary or Associate Member violates any of the principles of the code of ethics of the Association, or whose conduct or actions are not becoming to the honor conferred.

Section 6. Application Clearance

Effective September 1, 1947 all Secretaries of County or District Medical Societies shall submit a copy of all applications for membership in the County or District Society to the Executive Office of the Association before final action on the application is taken. The Executive Office will, in turn, within three days, submit the information on said application to the Bureau of Investigation of the A.M.A. for clearance as to the applicant's past history and actions. The report of the Bureau of Investigation and any and all information on hand in the Executive Office shall, in turn, be forwarded within three days after receipt to the Secretary of the County or District Medical Society. The

information contained therein will, in turn, be given to the Society's Board of Censors. The Executive Office of the Association shall not record any applicant's application on the records of the Association as a member in good standing unless the procedure outlined above shall have been accomplished. The Executive Office, however, shall have no right to question or decline applications that have followed this procedure if the County or District Society elects the applicant to membership at a regular meeting of the Society wherein a quorum is present.

CHAPTER II—Annual Session

Section 1. Time and Place

(a) Sometime during the spring of each year, and prior to the Annual Meeting of the American Medical Association, this Association shall hold an annual session, the place to be determined by the House of Delegates, and the time to be designated by a committee composed of the President, President-Elect and Secretary-Treasurer of the Association.

(b) During the annual session, the House of Delegates and the Council shall meet, as hereinafter provided. A general meeting shall be held and the Scientific Assembly shall meet in such sections as may be determined by the Committee on Scientific Work with the approval of the Council.

Section 2. General Meeting

General meetings shall be open to all registered members, guests of the Association and may be open to the Public. At the general meeting the President-Elect, who succeeds to the Presidency, shall deliver the President's address in initiation of his incumbency.

Section 3. Scientific Assembly

The Scientific Assembly shall meet in such general and section sessions as may be determined by the Committee on Scientific Work with the approval of the Council.

(a) Section Officers shall be appointed by the Scientific Work Committee and confirmed or rejected by the Council.

Section 4. Papers

No paper shall be presented unless the title be in the hands of the Committee on Scientific Work at least thirty (30) days before the first day of the Annual Meeting. No member may read more than one paper at any Annual Meeting except invited guests, and no paper or address shall occupy more than twenty (20) minutes in its delivery except special addresses by distinguished or invited guests on approval of the Committee on Scientific Work. No member, except by unanimous consent, shall speak more than once in the discussion of any paper nor longer than five minutes at any one time.

(a) Property of Papers

All papers read before this Association shall be its property, and immediately after being read, shall be deposited with the Secretary of the Section or the Executive Secretary of the Association. The authors of such papers shall agree that publication rights are reserved by the Association and except by consent of the Committee on Scientific Work, the authors shall not cause them to be published elsewhere until after they have been published in the Journal, providing, however, that if the Editorial Board of the Journal decides that the paper will not be published in the Journal that the Board may release the paper to the author, for such disposition as he may determine; provided further, that distinguished and invited guests delivering addresses or papers before the Association may reserve the right to use same as they may determine by previous arrangement with the Committee on Scientific Work.

CHAPTER III—House of Delegatees

Section 1. Representation

Each component county and/or district society shall be entitled to send to the House of Delegates each year one delegate or one alternate to represent that Society in the House of Delegates for each twenty-five (25) fully-paid, Honorary and Life Members, or any fraction thereof, in this Association. The delegates and alternates so elected shall assume office thirty (30) days prior to the next Annual Meeting and the list of delegates and alternates shall be published in the Journal of the Association issued the month previous to the Annual Meeting; provided, however, that each county society shall be entitled to one delegate and one alternate; and further provided that the number of delegates to which each component society is entitled will be based on a roster of its fully paid membership within thirty (30) days of the next annual session; and it is further specifically provided that the representation of district societies in the House of Delegates shall be apportioned on the basis of the individual counties comprising such district society, with each county in which five (5) or more members reside being entitled to at least one delegate. In case of counties having less than five members, their members shall be included in the total membership of the district society, and if the total membership is sufficient to entitle the district society to an additional delegate such additional delegate shall be elected by the district society at large.

Section 2. Meetings and Attendance

(a) Annual Meeting.

The House of Delegates shall meet annually at the time and place of the annual session.

(b) Special Meetings.

The House of Delegates may be called into and convene into special session only under the conditions provided in Article VII, Section 3, of the Constitution.

(c) Registered members at an annual session, and members in good standing present at a special meeting of the House of Delegates shall be permitted to attend such meetings, but except with unanimous consent of the House, only members of committees shall have the privilege of the floor under the circumstances stated in Section 4, subsection (d) of this Chapter. By a majority vote of the House, an executive session may be declared, during which time only qualified delegates will be permitted to attend the meeting.

Section 3. Quorum

A majority of registered and qualified delegates of this Association shall constitute a quorum.

Section 4. Reference Committees

(a) The speaker of the House of Delegates shall appoint, from among its members, reference committees to which reports and resolutions may be referred as may expedite the business of the annual session. Such reference committees shall be limited to three members, and may include those on resolutions, annual reports, place of next annual meeting, tellers and judges of elections, and other such committees as may be expedient.

(b) Delegates to the American Medical Association.

The House of Delegates shall elect delegates and alternates to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body. Such delegates or alternates shall attend the sessions of the American Medical Association. If a delegate or alternate to the House of Delegates of the American Medical Association dies, resigns or fails to qualify, the president, with the approval of a majority of the Council, may select a delegate to serve until the next succeeding or annual session of the House of Delegates of this Association, at which time a successor shall be elected for the unexpired term. Delegates to the American Medical Association shall be elected for a period of two years. The term of each delegate shall begin January 1 following the annual meeting at which time he is elected.

(c) District Societies.

When, in its judgment, the best interests of the Association and the profession will be promoted, thereby, the House of Delegates may organize district societies in any of the councilor districts of which all members of the component societies forming a part thereof shall

be members. Likewise, the House of Delegates may disassociate any County Society from a District Society upon petition by a County Society of a District Society.

(d) Committees.

The House of Delegates shall have authority to appoint committees, for special purposes and to authorize the appointment of such committees. Such committee members need not be members of the House of Delegates. They shall report to the House of Delegates and may be present and participate in the debate on the reports but shall not have the power to vote.

(e) Finance.

(1) The House of Delegates shall consider the annual budget of the expense of the Association submitted to it by the Council, and take such action as it deems necessary.

(2) The House of Delegates shall fix each year at the annual session the amount of the per capita dues which each component society and/or district is to collect from its members and transmit to the Association. The House may also, when it deems it necessary, impose a special assessment on each member of the Association, which likewise it is the duty of the affected component society to collect and transmit to the Association. The House may also accept voluntary contributions or donations for special purposes or the general fund.

Section 5. Order of Business

The following shall be the order of business of the opening and final sessions of the House of Delegates.

(a) Opening Session

(1) Call to order by the Speaker of the House, or the Vice-Speaker or other authorized officer in the absence of the Speaker.

(2) Report of the Credentials Committee, the qualifying of delegates to serve, and determination of the presence of a quorum.

(3) Consideration of minutes of the last session and such special sessions as may have been held succeeding the last annual session.

(4) Nomination of Officers

(5) Appointment of Reference Committees by the Speaker of the House of Delegates.

(6) Reports of Officers

(7) Reports of Standing Committees

(8) Reports of Special Committees

(9) Presentation of Amendments to the Constitution and/or By-Laws.

(10) Submission of invitations for the next annual session.

(11) Unfinished Business.

(12) Miscellaneous and new business.

(13) Recess

(b) Final Session

(1) Roll Call

(2) Consideration of unfinished business of the preceding session.

(3) Reports of Reference Committees.

(4) Miscellaneous and new business.

(5) Final Consideration of Amendments to By-Laws and further consideration of Amendments to the Constitution.

(6) Election of President-Elect and other Officers whose elections are in order at the session about to be concluded.

(7) Installation of Officers for the ensuing year.

(8) Announcement of Committee appointments by the recently installed President. (President-Elect until this time.)

(9) Unfinished business.

(10) Final adjournment.

The order of business, above detailed, may be modified for any session by a majority of delegates preseut at that session.

Section 6. Memorials and Resolutions.

No memorial or resolution shall be issued in the name of the Oklahoma State Medical Association until it has been approved by the House of Delegates.

CHAPTER IV—Councilor Districts and Councilors

Section 1. Apportionment

The State of Oklahoma is divided into fourteen (14) Councilor Districts and the counties alloted to each of such districts are as follows:

District No. 1: Craig, Deleware, Mayes, Nowata, Ottawa, Rogers, Washington.

District No. 2: Kay, Noble, Osage, Pawnee, Payne.

District No. 3: Garfield, Grant, Kingfisher, Logan.

District No. 4: Alfalfa, Beaver, Cimarron, Ellis, Harper, Major, Texas, Woods, Woodward.

District No. 5: Beckham, Blaine, Canadian, Custer, Dewey, Roger Mills.

District No. 6: Oklahoma.

District No. 7: Cleveland, Creek, Lincoln, Okfuskee, Pottawatomie, Seminole.

District No. 8: Tulsa.

District No. 9: Adair, Cherokee, McIntosh, Muskogee, Okmulgee, Sequoyah, Wagoner.

District No. 10: Haskell, Hughes, Latimer, LeFlore, Pittsburg.

District No. 11: Atoka, Bryan, Choctaw, Coal, McCurtain, Pushmataha.

Dist No. 12: Carter, Garvin, Johnston, Love, Marshall, McClain, Murray, Pontotoc.

District No. 13: Caddo, Comanche, Cotton, Grady, Jefferson, Stephens.

District No. 14: Greer, Harmon, Jackson, Kiowa, Tillman, Washita.

Section 2. Term of Councilors

(a) During the Annual session of 1949, Councilors and Vice-Councilors for the districts outlined in Section 1 of this Chapter shall be elected for the following terms:

Districts 1, 4, 7, 10, and 13 for one (1) year.
Districts 2, 5, 8, 11 and 14 for two (2) years.
Districts 3, 6, 9, and 12 for three (3) years.

(b) The terms of office of all Councilors elected after the 1949 Annual Session shall be three (3) years and until their successors are elected and qualified. No Councilor elected after the 1949 Annual session shall be eligible to serve continuously for more than two (2) elective terms. Provided, however; (1) The one and two year elective terms provided for in (a) of this section shall not be considered in the application of this limitation; (2) Service as a Councilor by appointment for completion of an unexpired term shall not be considered in the application of this limitation; (3) This limitation shall apply only to continuous service; (4) Service as ViceCouncilor shall not be included in the computation of service as Councilor under this limitation.

Section 3. Change of Districts

The House of Delegates, by vote of two-thirds of the delegates present at an Annual session, may change the composition of any one or more of the Councilor Districts.

CHAPTER V—Election of Officers

Section 1. Ballot

All elections shall be by ballot, and a majority of the votes cast shall be necessary to elect. If no nominee receives a majority of the votes cast on the first ballot, the nominee receiving the lowest number of votes on that ballot shall be dropped from the list and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of all votes cast, when he shall be declared elected. However, if there is only one nominee for an office, a majority vote, without ballot, shall elect.

Section 2. Nominations

Any member of the House of Delegates shall be per-

mitted to place in nomination for any office, except as herein otherwise provided, the name of any active member of the Oklahoma State Medical Association in good standing. Nomination of officers, councilors and vice-councilors shall be made during the opening session of the House of Delegates as shown in Chapter III, Section 5, subsection 4 of these By-Laws.

Section 3. Time of Election

Election of officers shall be held at the second meeting of the House of Delegates as provided by Chapter III, Section 5, subsection (b) of these By-Laws.

Section 4. Installation

The President-Elect shall assume the duties of President at the close of the next annual session after his election. The delegates to the American Medical Association shall assume office on January 1 following their election. All other officers shall assume office at the close of the Annual session at which they are elected. The terms of office of all officers shall be as herein provided, or until their successors have been elected and qualified.

All retiring officers of this association shall promptly turn over to their successors all papers, records, books, and equipmeut of their office immediately upon being succeeded.

Section 5. Nomination of Councilors

One Councilor and one Vice-Councilor is to be elected from each district as hereinbefore provided, however, the delegates from the districts hercinbefore provided shall nominate one or more candidates for councilors and vice-councilors in a district caucus at a recess of the House of Delegates just prior to the nomination of officers, and the one receiviug the majority vote of the House of Delegates shall be the Councilor.

CHAPTER VI—Duties of Officers

Section 1. President

The President shall be a member of the Council, and shall be the Chairman and presiding officer thereof. He shall preside at all general meetings of this Association. He shall fill vacancies on Standing Committees and appoint such special Committees as he deems advisable or under instruction from the Council. He shall be ex officio member of all committees he appoints. He shall be Chairman of the Council and, perform such other duties as pertain to the principal administrative officer as custom and parliamentary usage may require. He shall be the acknowledged head and personal representative of the medical profession of the State during his term of office, and so far as practical, shall visit the districts of the State and assist the Councilors in building up county and/or district societies. Upon invitation of his successor to the presidency or of the Council, he may sit as a member of that body in au advisory capacity for one year succeediug his retirement. As Chairman of the Council, he shall have the right to cast his vote as a Councilor or reserve same to break a tie.

Section 2. Vice-President

In the event of death, resignation, removal from the State, or the disqualification or disability of the President to continue with his duties, the Vice-President shall succeed to the Presidency to complete the unexpired term. In the absence of the President he shall act as Chairman of the Council and preside.

Section 3. President-Elect

At the close of the next annual session following his election, he shall automatically succeed to the Presidency.

Section 4. Speaker of the House of Delegates

The Speaker of the House of Delegates shall be a member of the Council. He shall preside at all meetings of the House of Delegates when present, and in the absence of the Vice-Speaker, may designate any member of the House to preside for him temporarily. He shall appoint such Reference Committees as may be necessary to expedite the business of the annual session, and shall perform such duties as custom and parliamentary usage may require of the presiding officer. During the absence of the President and Vice-President or other cause of vacancy of the Presidency, the Speaker of the House shall act in the capacity of Acting President to complete the unexpired term, this in addition to his other duties as Speaker of the House of Delegates.

Section 5. Vice-Speaker of the House of Delegates

The Vice-Speaker shall preside at meetings of the House of Delegates in the absence of the Speaker of the House, and shall succeed to the Speakership in the event of death, resignation, or other cause creating a vacancy in the Speakership of the House of Delegates.

Section 6. Secretary-Treasurer

The Secretary-Treasurer shall be a member of the Council and shall keep the minutes of the proceedings of this body. As Treasurer, he shall give bond at the expense of the Association and in such an amount as may be required by the Council. He shall receive all funds for dues and assessments collected by the Executive Secretary as well as other receipts collected for advertisiug, bequests, douatious and other sources of income, and obtain an accounting from the Executive Secretary concerning same. He shall deposit the funds collected in a depository approved by the Council, and shall disburse from such accounts expenses approved by the Council on a voucher, signed by the Executive Secretary and countersigned by the President. He shall present the Council and House of Delegates, annually, a report of receipts and expenditures and the state of the funds in his hands, and shall subject his accounts to such examination as the Council and House of Delegates may order. Investments of reserve funds shall be made by the Treasurer on order of the Council in United States Government bonds and be held by him in safe keeping, subject to the order of the Council. He may borrow money in the name of the Association, and may use as security, if necessary, property held by him iu safe keeping, ouly ou the order and authority of the Council.

Section 7. Executive Secretary

The Executive Secretary shall be an employee of the Oklahoma State Medical Association and need not be a physician or a member of the Association. He shall be employed by the Council which shall fix his term of employment and designate his salary. He shall attend all meetings of the House of Delegates and shall be the recording secretary of both the House of Delegates and the Council. When in executive session, the House of Delegates and/or the Council may, by a majority vote, permit his presence. He shall keep minutes of the proceedings of all sessions and shall be secretary of all committees of the Association when called upon and available, and assist them in the performance of their duties. He shall, under instruction from the Committee on Publicity, issue and send to lay publications such articles as may be prepared and authorized for general publication, and secure and assist medical speakers to address, on invitation, lay organizations on subjects pertaining to individual or community health. He shall, whenever requested, assist any of the component societies of the Association in securing speakers or otherwise preparing a program for special meetings. He shall, at all times hold himself in readiness to advise and aid, so far as practical, any and all officers and committees of the Association. He shall be custodian of all records, books and papers belonging to the Association, except such as properly belong to the Secretary-Treasurer, and shall keep account of and promptly turn over to the Secretary-Treasurer all funds of the Association which come into his hands. He shall be bonded at the expense of the Association in such an amount as shall be required by the Council. He shall provide for the registration of the members and delegates at the Annual Meeting and cooperate with the Credentials Committee in the preparation of a list of the elected and qualified delegates from the component societies. He shall, with the cooperation of the secretaries of the componeut societies, keep a register of all

licensed physicians of the state and cooperate with the American Medical Association in maintaining a complete roster of membership and detailed information thereon. He shall report in writing, promptly, proceedings of the House of Delegates, Council, or important committees and any other matters of importance or significance which should be published, to the Editorial Board of the Journal for their approval for publication. He shall aid the Councilors in the organization and improvement of county and/or district societies and in the extension of the power and usefulness of this Association. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committeemen of their appointment and duties. He shall employ such office assistants as may be ordered by the Council, and shall make an annual report to the Council and the House of Delegates. He shall supply each component society with necessary blanks for membership and annual reports. He shall keep an account with the component societies charging against each society its assessments, collect same and promptly turn the funds over to the Secretary-Treasurer. Acting with the Committee on Scientific Work and the Editorial Board of the Journal, he shall issue all programs. He shall maintain an office in the capital city of the State, providing for such office space and at such expense as may be approved by the Council. His office shall be designated as the Official headquarters of the Association. Travel expense and other necessary expense in the conduct of his office and in performance of his duties, shall be submitted monthly to the President.

CHAPTER VII—The Council

Section 1. Meetings

(a) The Council shall hold regular meetings during the year. Such meetings to be every three months with one meeting held no later than 30 days prior to the date of the Annual Meeting at which time the budget of the Association will be considered.

(b) The Council shall meet at the call of the President or by petition to the president by a majority of the Council.

(c) The Council shall meet daily during the Annual Session.

(d) The Council shall meet on the last day of the Annual Meeting for the installation of newly elected members. They shall program the mandates and recommendations of the House of Delegates and pursue other duties as provided by the Constitution and By-Laws.

Section 2. Presiding Officer

The President of this Association shall be the Chairman and presiding officer of the Council, and, in his absence, the following officers in succession shall assume such duty: Vice-President, Speaker of the House, Vice-Speaker of the House, and President-Elect.

Section 3. Annual Reports

The Council through its Chairman, shall make an annual report to the House of Delegates to be presented during the first meeting of the annual session.

Section 4. Individual Duties of Councilors

Each Councilor, shall be organizer, peace maker and censor for his district. He shall visit each county in his district at least once each year for the purpose of organizing component societies where none exist; keep in touch with the activities, and to aid in the betterment of the component societies of his district, and to inquire into the conditions of the profession and improve and increase the zeal of component societies and their members. He shall make an annual report of his activities, and with such recommendations as may be indicated, to be presented to the House of Delegates at the annual session or published in an issue of the Journal preceding the annual session.

Section 5. Collective Duties of Councilors

(a) The Council shall be the executive body of the House of Delegates and this Association, and between meetings shall exercise the powers conferred on the House of Delegates by this Constitution and By-Laws, providing that in the exercise of the interim powers thus conferred upon it, the Council shall take no action and consider no legislation contravening any general policy which shall have been adopted by the House of Delegates and which, at that time, is still in effect.

(b) The Council shall be the Board of Censors of the Association and shall consider all questions involving the privileges and standing of members, whether in relation to other members, to component societies, or to the Association as a whole. All questions of an ethical nature brought to the attention of the House of Delegates, the general meeting, or to officers of the Association shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members of component societies and all matters referred to the Council on appeal from component societies or from the individual councilors. Its decision in all cases involving questions regarding membership in this Association shall be final, except those matters involving jurisdiction of the Judicial Council or other appropriate body of the American Medical Association, which by right the member or component society may appeal to the American Medical Association. In such an event, the finality of the appeal shall be suspended until a decision has been received from the American Medical Association.

(c) The Council shall systematically endeavor to promote friendly intercourse among physicians of the same locality, as well as throughout the state, shall encourage post-graduate and research work as well as home study, and shall endeavor to have the results utilized and intelligently discussed in component societies; shall consider and advise as to the material interests of the profession and of the public in those important matters wherein it is dependent on the profession; and shall keep informed and advised concerning medical and public health legislation and diffuse popular information in relation thereto.

(d) The Council shall have authority to organize in the sparsely settled sections of the State, the physicians of two or more counties into societies to be designated by hyphenating the names of two or more counties so as to distingnish them from other classes of component societies and these societies, when organized and chartered, shall be entitled to all the privileges and representation provided therein for county societies until such counties may be organized separately.

Section 6. Component Societies

(a) Each Component Society of this Association shall file a copy of its Constitution and By-Laws with the Executive Secretary.

(b) Charters shall be issued to county societies on application to and on approval of the Council and shall be signed by the President and Secretary-Treasurer of this Association. Upon recommendation of the Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of the Constitution and By-Laws of this Association. No charter shall be issued to any component society unless the membership of such society is qualified under Chapter I(Sections 1 and 2, of these By-Laws. From the time of adoption of this amendment it shall be mandatory for each component Society to secure a charter within six months.

Section 7. Employees and Headquarters

All employees of this Association, including the Executive Secretary, shall be selected or approved by the Council, which shall fix the length of employment, salaries, and allowances. It shall approve the selection of headquarters of the Association at the state capital city by the Executive Secretary, approve assistants employed by him and determine or approve the expense involving same.

Section 8. Committee on Appropriations and Auditing

The Council shall prescribe the methods of account-

ing and, through a committee of three of its members to be known as a Committee on Appropriations and Auditing, shall audit all accounts of this Association and receive reports for its approval or rejection. It shall adopt an annual budget providing for the necessary expenses of the Association, which shall be prepared and presented for approval by the House of Delegates.

Section 9. Salaries

Salaries of all employees of the Association shall be fixed by the Council.

Section 10. Exhibits

Exhibits at annual meetings, arranged for by the Executive Secretary, shall be approved and authorized by the Council. No article or compound shall be allowed among the exhibits which is held unethical or improper by the Council on Pharmacy and Chemistry, Council on Physical Therapy, Council on Foods, and the Bureau of Exhibits of the American Medical Association.

Section 11. Editorial Board

The Council shall select members of the Editorial Board of the Journal of the Oklahoma State Medical Association, herein referred to as the Journal, as provided for in Chapter VIII of these By-Laws.

Section 12. Journal

Upon the recommendation of the Editorial Board and the Executive Secretary, the Council shall authorize the issuance of the Journal and provide necessary appropriations for the publication of the same. It shall have final jurisdiction in the matter of policy and in regulating the activities and authority of the Editorial Board and Executive Secretary.

CHAPTER VIII—The Journal

Section 1. Name

The official publication of the Association shall be the Journal of the Oklahoma State Medical Association and referred to in these By-Laws as the Journal.

Section 2. Publication

The Journal shall be published once each month during the calendar year and distributed on or about the first of each month for the month for which it is named and numbered.

Section 3. Management

The Executive Secretary shall be the business manager of the Journal, shall arrange for its printing, have charge of the advertising and other business matters relative to the publication of same, subject to the advice and approval of the Editorial Board and the Council.

Section 4. The Editorial Board

The Editorial Board shall consist of three members selected by the Council for a term of three years, subject to removal by the Council, if and when the interests of this Association demand same.

(a) Immediately upon the adoption of these By-Laws, the Council shall elect members of the Editorial Board, one each for terms of one year, two years, and three years. Thereafter, at the expiration of the term of each member, a successor shall be elected for a term of three years. The Council shall designate one of the elected board members as Editor-in-Chief, and this designation shall, at all times, be subject to change by the Council by giving thirty (30) days written notice to the Editor-in-Chief. Vacancies on the Board shall be filled by the Council for the unexpired terms.

(b) The Editorial Board shall have full charge of the editorial policy of the Journal; shall select articles for publication among papers read at the previous annual session or any original contributions other than such papers which, in their judgment, will promote the best interests of the scientific program and policy of this Association; shall supervise and approve advertising material submitted for publication by the Executive Secretary; and perform any and all other duties as custom and usage may dictate to promote the best interests of the Association and in producing the best medium of advancing scientific and other information for the members of this Association.

(c) The Editorial Board will be responsible only to the Council, which shall have authority to change or modify the policy and management of the Board, in publishing the Journal.

(d) The Executive Secretary shall keep a detailed account of the transactions in publishing the Journal, including income therefrom and expenses. A separate report, pertaining to this matter, will be submitted for approval to the Council.

CHAPTER IX—Committees

Section 1. The standing committees of this Association shall be Annual Session, Credentials, Scientific, Work and Exhibits, Constitution and By-Laws.

Section 2. Manner of Appointment

The Committee on Annual Session shall be composed of the President, President-Elect, Secretary-Treasurer. All other Standing Committees designated in Section 1 shall be composed of six members who shall be appointed by the President, subject to approval of the Council, for a term of three years, and until a successor has been appointed and qualified; appointments being staggered so that there shall be only two appointed in any one year unless a vacancy shall occur, which shall be filled by the President for the unexpired term of the vacancy except the Credentials Committee which shall be governed by Section 3 (a) of this Chapter.

Section 3. Committee on Credentials

(a) The Committee on Credentials shall be members of the House of Delegates. Members appointed to this Committee shall be members of the House of Delegates at the time of appointment. If any member of the Committee is subsequently not re-elected to the House of Delegates by his County Society or is otherwise disqualified as a delegate, the President shall appoint a regularly certified Delegate to fill the vacancy on the Committee left vacant by the member of the Committee who cannot qualify and the newly appointed member shall serve the unexpired term as long as he is qualified.

(b) The Committee on Credentials shall receive from the Executive Secretary a list of the members in good standing of each component society immediately prior to the Annual Session. They shall also obtain a list of duly elected delegates from each component society and shall determine the eligibility to sit as the authorized representatives of their respective component societies.

(c) In case of contest of delegates from any component societies, the Credentials Committee shall sit in judgment thereon and recommend for approval by the House of Delegates their findings. At the opening session of the House of Delegates, the Credentials Committee shall submit an authorized list of delegates and determine the presence of a quorum before the House of Delegates is authorized to proceed with official business.

Section 4. Committee on Annual Session.

The Committee on Annual Session with the advice and assistance of the Executive Secretary shall provide suitable accommodations for the meeting of the Association in the city designated by the House of Delegates at the last previous annual session. They shall designate special committees to have charge of the various activities of the annual session and cooperate with committees of the local society of the convention city. With the cooperation of the Committee on Scientific Work and Exhibits programs of the session shall be prepared sufficiently in advance for publication in the Journal preceding the Annual Session. They shall have jurisdiction over Scientific Exhibits and applications for such should be approved by the Committee before the Executive Secretary is authorized to provide space for them. This Committee is authorized to select and appoint any such sub-committees as, in its opinion and judgment, will facilitate the carrying on the annual

session to the best interest of all concerned.

Section 5. Committee on Scientific Work and Exhibits

The Committee on Scientific Work and Exhibits shall determine the character and scope of the scientific proceedings of the Association at each session, subject to the instruction and supervision of the Council. At least thirty (30) days previous to the annual session, they shall prepare and issue a complete program announcing the order in which papers, discussions and other business shall be presented, and which shall be published in the Journal issued previous to the annual session.

Section 6. Committee on Constitution and By-Laws

The Committee on Constitution and By-Laws shall consider and recommend to the House of Delegates changes in the Constitution and By-Laws to the end that the basic framework of the Association shall accomplish the desires of the membership. The Committee shall meet at such time and place that will allow for the consideration by the House of Delegates of recommended changes to the Constitution and By-Laws at the first meeting of the House of Delegates at which time they might be voted on as otherwise provided in the Constitution aud By-Laws.

Section 7. Special Committees

(a) Special Committees may be appointed by the President on his own initiative or on order of the Council and/or the House of Delegates.

(b) All special committees shall consist of three or more members and shall be appointed to serve for one year concurrently with the term of office of the President appointing such committee unless previously dismissed by him.

CHAPTER X—Dues and Assessments

Section 1. Dues

(a) Oklahoma State Medical Association Dues

The amount of annual dues shall be determined by the House of Delegates during each annual session for the next succeeding calendar year, and shall be levied per capita on the members of the Association. Dues shall be due and payable on or before January 1 of the year for which they are levied. The Secretary of each component society shall cause to be collected and shall forward to the Executive Secretary the dues for its members, together with such data as shall be required for a record of its officers and members. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the Executive Secretary of this Association on or before March 1, shall stand suspended until his name is properly reported and his dues for the current year properly remitted.

(b) Americau Medical Association Dues.

All active members of this Association shall be required to pay such annual dues and/or Special Assessments of the American Medical Association as may be levied by its House of Delegates. American Medical Association dues and/or Special Assessments shall be collected by the Secretaries of the component Societies and forwarded to the Executive Office of this Association, in the manner provided for State Association Dues or as provided by the American Medical Association.

(c) Half Dues

Any member who is a full time employee of any subdivision of Federal, State, County or Municipal Government non-profit organizations, or medical school, who receives no outside remuneration from his medical skills and whose annual remuneration does not exceed five thousand dollars including all subsistence allowances or has not been engaged in the practice of medicine in excess of two years since his hospital training and has not held a full and active membership in the State Medical Association, shall be assessed for one-half of the annual dues of the Association. The eligibility for membership falling within these qualifications is to be a decision of the County Medical Society and an option of the applicant for membership. This membership shall be considered the same as an active membership and shall include all rights and privileges of an active membership. Any applicant for membership who has not previously held membership in this Association shall pay dues on the basis of the date he is elected to membership in the Couuty Medical Society. If elected during the first quarter of the year, he will pay full dues and if elected in any subsequent quarter, he will pay dues based on that quarter and the remainder of the year.

(d) Undue Hardship.

Any member who suffers a temporary physical disability or who for other good and suffcient reasons would suffer an undue hardship by the payment of his dues in this Association may be granted a waiver of such dues for not more than one year at a time on recommendation by the Component Society of which he is a member if that component society has also waived his local dues, and upon approval of such recommendation by the Council.

(e) Military Exemptions.

Any member of this Associaiton who enters active duty in the Armed Forces of the United States during any period of national emergency shall be exempt from the payment of his dues in this Association for the calendar quarter of the year in which he enters active duty and for such time as he remains on active duty and until January 1, following his release from active duty. Provided further that any member who has paid his dues in full prior to his entry on active duty shall receive a refund of such dues for the calendar quarter in which he eutered active duty and for the remaining quarters of the year for which his prior payment was made. Provided further that any member of this Association who is the spouse of a member exempt from dues under this sub-section and who by reason of the military service of the other spouse finds it necessary to discontinue the active practice of medicine, shall be entitled to the same exemption privileges as provided in this sub-section for those iu military service.

Section 2. Assessments

The House of Delegates shall have the authority to levy special assessments on the membership of this Association in addition to regular dues as provided herein. Such special assessments are to be on an equal per capita basis except those active members who are not required to pay more than one half of the regular yearly dues, this category of members shall be subject to pay one-half of all special assessments made on active members. Special assessments are to be collected in the same manner as dues; provided, however, that the House of Delegates shall provide for the time of paying such assessment and establish date of delinquency of same. The method of collecting and reporting of such assessments shall be provided as for dues in Section 1 of this Chapter.

Section 3.

The record of payment of dues and assessments on file in the Office of the Association shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Association and of the House of Delegates, and as to membership status in the American Medical Association.

CHAPTER XI—Component Societiees

Section 1. County and District Societies

All county or district societies now chartered and in affiliation with the Oklahoma State Medical Association, or those that may hereafter be organized under the authority of the Council of this Association, are acknowledged as component societies as referred to in this Constitution and By-Laws provided that their Constitution and By-Laws do not contain provisions in conflict with the Constitution and By-Laws of this Association. The Council, with the approval of the House of Delegates, shall have the authority to revoke the charter of any component society whose actions are in conflict with this Constitution and By-Laws. Lack of representation of a duly accredited delegate or alternate at three consecutive annual meetings of the House of

Delegates of this Association shall be sufficient grounds for withdrawal of a charter by a majority vote of the House of Delegates.

(a) Reqnirements for Establishing and Maintaining a County Society.

To create or re-activate a County Medical Society, the provision of Section 3 of this Chapter of these By-Laws must be met. To maintain a County Society the number of active members must be at all times at least five in nnmber, the Society mnst meet at least six times each year with one meeting being in either November or December for the purpose of electing officers, delegates and alternates of the County Society for the succeeding year. The Secretary of the Society at the time of the election of new officers shall immediately transmit in writing to the Execntive Office of this Association the results of its election.

(b) To Create and Maintain a District Society.

As provided in Chapter III, Section 4, subsection (c), the House of Delegates shall approve the creation of District Societies and representation in the House of Delegates shall be in conformity with the provisions of Chapter III, Section 1.

To organize a District Society there must be at least ten active members of this Association within the District and at least one member shall reside in each of the respective counties of the District. The County Societies and members of this Association involved in the organization of the District Society shall by mutual agreement notify the Executive Officers of this Association regarding their intention. The reqnest shall be presented to the Council at any regular meeting, at least ninety (90) days prior to the annual meeting of this Association. The Council, with their recommendation, shall publish in the Journal at least thirty days prior to the Annual Meeting, the reqnest for an organization of a District Society. When such a District Society is approved by the Honse of Delegates, it shall be issued a charter and the component county societies shall surrender their charters to the Executive Office of the Association. The provisions of this Constitntion and By-Laws governing County Societies shall apply to District Societies.

Section 2. Membership

(a) When a member in good standing of a com ponent county society, except members who are in the United States Military or Public Health Service, State Public Health Service, or one whose employment makes his residence in any community temporary, moves to another connty in the state, he shall be given a written certificate of his membership by the secretary of his county society without cost. This certificate shall accompany application for membership in the county society in the county to which the member has moved. Pending action on the application, such member shall be considered in good standing in the society from which he was certified. In case of rejection, the applicant may appeal for relief to the Council. Appeal mnst be made in writing and mnst be delivered into the hands of the Council not more than thirty (30) days following date of notice of rejection. Consideration of the appeal shall be given by the Council at the earliest time possible. Not more than ninety (90) days shall elapse following the date the appeal has been received by the Council until a hearing shall be given to the applicant and to the component county society, and the action taken by the Council on the appeal shall be final. Under no circnmstances shall membership be retained in a component county medical society for a period longer than one year following the issuance of a certificate of removal. Any physician living near a county line may hold membership in the medical society of the county adjoining his residence if it is more convenient for him to attend the meetings of the medical society of that adjoining connty, but before a physician is affiliated with a medical society in a connty in which he does not reside, the consent of the medical society in the county in which he does reside mnst be first obtained. Should no County Society exist in the Connty in which a physician resides he may be eligible for membership in an adjoining Connty Society nntil such time as there are sufficient qualified physicians residing in the county to formulate a Society within the county.

(b) Should the license of a member of a component society be suspended for any period, his name shall be automatically dropped as of the date of snspension, and he shall not be entitled to reinstatement of membership in the State Association until January of the year following his period of suspension.

Shonld a case regarding the licensnre of a physician be pending before the Oklahoma State Board of Medical Examiners, membership privileges in the State Association cannot be granted the physician in question until such time as a final determination has been reached by said Board.

(c) A component society may censure, snspend or expel any member for any cause set out in the Constitution and By-Laws of said society or for any cause deemed snfficient at law for disciplinary action.

(d) Disciplinary Procedure.

No disciplinary action shall be taken against a member of a component society without serving the accused at least ten (10) days in advance of trial with a written copy of the charges against him and affording him the opportunity of a hearing. Shonld a hearing or hearings be held, records thereof shall be kept by the secretary of the component society, who, within fifteen (15) days after the component society has taken final action, shall transmit to the Connell of this Association certified copies of such records.

(e) Appeals.

Any member against whom disciplinary action has been taken who feels that he has not been given a trial in accordance with the provisions of this Constitution and By-Laws and the Constitntion and By-Laws of his component Society shall have the right to appeal to the Connell, under snch reasonable rules as the Council may adopt with respect to such appeals. To be considered by the Council, appeals must be made in writing withing sixty (60) days after the appellant has been given written notice of censure, suspension or expulsion which is contemplated.

Upon receipt of an appeal the Executive Secretary of this Association shall write immediately to both the president and the secretary of the Component Society, notifying them that appeal has been made and demanding certified copies of all records in the case which have not been submitted previously, as provided in snbsection (d) of this Section. If the component society fails to snbmit certified copies of records within sixty (60) days of demand, the appellant shall be reinstated to membership in good standing by the Council of this Association.

Section 3. Charter

Only one component medical society shall be chartered in each county. No County Society, however, shall be chartered or hold its charter unless at the time chartered the petition for charter is signed by at least five physicians believed to be eligible for charter memberships in the society.

(a) Charters of Connty Medical Societies may stand snspended or may be revoked should the number of members fall below that of the minimum requirements for two consecutive years.

(b) Custody of Charter

The charter of each component society as issued by the Oklahoma State Medical Association shall be preserved and be in the custody of the Secretary of each component society.

(c) To Dissolve District Societies.

Shonld the members of a District Society desire to disassociate themselves as a District Society the action

shall be taken at a regular meeting of the District Society in sufficient time to give ninety days notice of such request to the Executive Office of the Association and the actiou of the District Society will be presented to the House of Delegates for approval. Co-existing with this action the physicians from the counties making up the District Society may petition the House of Delegates for the creation of County Societies within their respective counties as otherwise provided in these By-Laws.

Following the holding of the regular meeting of the District Society should the members from the County desiring to withdraw still be of the same decision, a petition signed by a majority of the members residing in the County wishiug to withdraw shall be submitted to the House of Delegates through the Executive Office of the Association at least ninety days prior to the Annual Meeting.

Co-existing with this action the physiciaus from the withdrawing County may petition the House of Delegates for the creation of a County Society within their County as otherwise provided in these By-Laws.

Section 4. Constitution and By-Laws

Each component society shall have a Constitution and By-Laws. These shall be in conformity with the Constitution and By-Laws of the Oklahoma State Medical Association, and a copy thereof shall be transmitted to the headquarters of this Association for approval aud record. Any amendment or change in such Constitution and By-Laws of component societies shall be submitted to the Council for its approval and then filed with the Executive Secretary.

Section 5. Functions and Duties of Component Societies

Each component society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted toward improving the science and art of medicine and the welfare of the people. Systematic efforts shall be made by each member aud by the society as a whole to increase the membership until it includes every doctor of medicine who meets the qualifications for membership in the County.

(a) Each component society shall keep an official record book or books, which shall include an official copy of its Constitution and By-Laws, a roster of its membership, aud all personal data pertaining to members which may be of historical and other use.

Section 6. Certification of Delegates

Each component society, at least sixty (60) days prior to the annual session of this Association, shall elect one or more delegates and an equal number of alternates to represent it in the House of Delegats, in accordance with Chapter III, Section 1, of these By-Laws. The secretary of each component society shall send a list of delegates and alternates to the Executive Secretary of this Association as soon as possible before the annual session, and provide each delegate and alternate with a certification of such election for presentation to the credentials committee, if such procedure is deemed necessary or advisable by said Committee. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

CHAPTER XII—Parliamentary Procedure

Where the Constitution and By-Laws of this Association does not make provision for parliamentary procedure, deliberations of this Association, committees, or parts thereof, shall be conducted in accordance with parliameutary usage as defined by the latest edition of Roberts Rules of Order.

CHAPTER XIII—Amendments

These By-Laws may be amended at any annual session by a majority vote of the delegates present at that session, provided that the proposed amendment has been properly submitted in writing to the House of Delegates at the first meetiug of the anuual session and has laid on the table at least until the following session.

CHAPTER XIV—Special Recognition of Members Who Have Been in the Practice of Medicine at Least Fifty Years

Any physician, a member of this Association, who has been engaged in the active practice of medicine for fifty years and a member of this Association for the preceding five years on recommendation of his County or District Society shall be entitled to have his name entered on a special roster maintained by the State Association in recognition of his services to humanity for a half century.

The qualifying member shall receive special recognition at a meeting of the House of Delegates during the Annual Meeting and shall be presented with a suitable certificate from the Oklahoma State Medical Association in commemoration of his outstanding length of service iu the profession. Should circumstances prevent the member being present at the Annual Meeting to receive this honor, the presentation will be made at an appropriate time and place to be selected by the president.

CHAPTER XV—Enabling and Repealing Clause

Section 1. Upon adoption of these amendments to the By-Laws, all previous By-Laws, motions of record, rules and regulations iu conflict with same are hereby repealed, provided, however, that all officers of this Association now in office shall continue their incumbency until their successors are elected, as provided in these By-Laws.

Section 2. Any Chapter, Section, subsection, or any part thereof in conflict with the present Constitutiou of the Oklahoma State Medical Association shall be of no effect, but all other parts of these By-Laws not so conflicting with the present Constitution shall be in full force and effect immediately upon its passage.

(Adopted 1940) (As Amended Through 1952)

MALPRACTICE CLAIMS

During the past year there have been many changes which have focused the attention of both physicians and their insuranee earriers on the problems with which we are confronted in handling professional liability claims.

The inerease in the number of claims and the extravagant amounts of the suits filed have so alarmed the companies that they have become extremely wary of carrying the insurance at any price. As has been pointed out many times, the majority of claims and lawsuits are not well founded and the final experience on pending claims may yet be determined favorably. Whether or not the experience is finally favorable depends entirely on the interest in and active support of prevention programs by both doctors and insurance eompany representatives.

Cost, also, will be determined by the same faetors. If the present trend toward inflationary judgments continues, either the cost will beeome prohibitive or the insurance companies wil discontinue writing the coverage. Insurance eompanies are not philanthropic organizations. They must either show a profiit to the stockholders or they, the owners, will invest elsewhere. Deficit finaneing is not considered good management by the average stock holder and when the premium income fails to exceed the claims, expenses and taxes paid, heads begin to fall and drastie changes of policy occur.

The control of mal-practiee claims is largely a matter of publie relations as well as meticulous care in treatment. Far too often it is heard, ''My automobile receives better care at the shop than I do at the doctor's office.'' Impersonal production line efficiency does not appeal to the average patient. His pain is personal and he wants to tell the doetor and not have his history taken by a strange receptionist, no matter how attraetive.

We will continue to have the usual number of claims because of unfortunate results of surgery, anesthesiology and radiology, as well as occasional elaims for fraud, assault or violation of privileged communication. The vast majority of these will be found to be without foundation in fact and could have been avoided except for ill advised comment by a doctor not conversant with the facts of the case. We must face the fact that every mal-practice claim or suit is predieated on testimony that some doetor will be expected to give at the trial. If this witness, usually reluetant, had extended to his brother physician the common courtesy commanded by his calling neither would have been embarrased by the patient or his attorney.

For the past three years there has been an increasing number of claims based on special contract thereby circumventing the two years statute of limitations applicable to mal-practice claims. The patient alleges, under the guidance of expert legal apostates, that the doctor guaranteed results or a eure. The utmost care need be taken to avoid, either by word or action, anything that might be interpreted as a warranty. The favorite expression of one doctor ''good as new'' has risen to smite him more than once. Again and again the choice of words spoken in consultation or in a written report has been the basis of a mal-praetice claim where there was no mal-practiee.

Let us review briefly the history of Professional Claimes in this area. Twenty years ago there was an alarming increase in the number of claims. Doctors were testifying promiscuously against each other and damage suit lawyers were thriving. No single insurance company had enough business of this elass to make it worth while to devote time and expense to elaim prevention. Very few of the companies would write the class at any price.

Then there was developed a system of edueation and elaim prevention which was so suceessful that for the next fifteen years the experience was so favorable that the premiums charged were about one-third of the basie rate charged at the inception of the program.

During the past five years this program has been practieally abandoned. Many doctors have adopted the attitude of ''let them pay, I can't be bothered.'' Finally the company that sponsored the program was obliged to withdraw from the field.

Your Insurance Committee and Seeretary then spent long hours in considering proposals from many companies and determining the proper rate to be charged. Only one company was willing to adopt the plan of operation that had proved so favorable in the past. With the assurance of active support and eontinuance of educational and preventive programs the St. Paul-Mercury Indemnity Company issued a Master Policy to the Oklahoma State Medical Association under which the individual doctors may purchase certificates of insurance at a substantial saving in premium and be assured of competent handling of their elaims and lawsuits. The program has been resumed and has already showu marked affect in a substantial reduction in the number of claims and suits filed. This program merits your active support and cooperation. It cannot succeed otherwise. Unless the program is supported with your premium dollar as well as your cooperation in handling of claims, no company can afford to take the risk of highly vulnerable underwriting in so limited a field.

A final word about claim prevention, all doctors know the commonplace everyday rules of care and eonduct without repeating. But if they will take special care to avoid cases beyond their ability or facilities, report claims promptly and give complete information, call in consultants in doubtful or difficult cases, take euough X-rays, cultivate a ''family doctor'' professional manner, refrain from the practice of law and carefully avoid washroom and reception hall diseussion of cases, the number of claims will be greatly reduced.

VOLUNTARY HEALTH AND WELFARE AGENCIES

THE AMERICAN CANCER SOCIETY, INC.

OKLAHOMA DIVISION

937 Commerce Exchange Building

Oklahoma City, Oklahoma Telephone REgent 9-2659

Gregory E. Stanbro, M.D.
Chairman, Executive Committee

Menter G. Baker, Jr.
Executive Director

PROGRAM

Education (lay and professional), Service and Research.

EDUCATION — LAY

Education of the public is the basic aim of the American Cancer Society—that is, to bring to every person in the country sufficient knowledge about cancer so that he will not lose his life needlessly, impressing the public with the importance of early diagnosis followed by proper and adequate treatment. This is an enormous and challenging task and is being accomplished through the help of hundreds of volunteers throughout the State.

The Society uses every conceivable means to get cancer facts to the public. This is done through the distribution of millions of cancer educational pamphlets, the newspapers, radio, television, exhibits, lectures and films.

Statewide organized groups are the strong right arm of carrying out the lay educational program—the Home Demonstration Council, the Oklahoma State Federation of Women's Clubs, Business and Professional Women's Clubs, the American Legion Auxiliary, Order of the Eastern Star, the Women's Auxiliary to the State Medical Association, schools, civic clubs, Federal and industrial groups.

Currently, the Division is waging a real crusade against breast cancer through extensive showing of the film "Breast Self-Examination." This film is for female audiences and is being shown throughout the State with great success. It is shown only with a physician present to enlarge the theme of the film and to answer audience questions.

The other current film "Man Alive" is excellent for both men and women's group and is particularly good for all civic groups. This 12-minute film presents in cartoon fashion the sometimes serious consequences of ignoring cancer's danger signals and is done in an amusing and yet effective manner.

EDUCATION — PROFESSIONAL

Alongside its extensive lay educational activities the Society has developed a program to keep the professional man informed of all that is currently known about the diagnosis and treatment of cancer. To help the physician — especially the general practitioner — keep abreast of current developments the Society provides:

Literature

1. "CA—A Bulletin of Cancer Progress" published bimonthly by the American Cancer Society and distributed to all members of the Oklahoma State Medical Association.
2. A series of monographs published by the American Cancer Society and distributed to all members of the Oklahoma State Medical Association.
3. "Cancer: A Manual for Practitioners" published by the Massachusetts Division of the American Cancer Society and previously distributed to all members of the OSMA.

A limited number of copies are available to new members who have not received it. The Oklahoma Division will be glad to secure for any physician copies of any cancer literature published anywhere. A complete list of all cancer literature published outside the Iron Curtain is on file in the Division Office.

Films

Professional films currently available are:

1. Cancer: The Problem of Early Diagnosis (First in a series).
2. Breast Cancer: The Problem of Early Diagnosis (Second in a series).
3. Gastrointestinal Cancer: The Problem of Early Diagnosis (Third in a series).
4. Uterine Cancer: The Problem of Early Diagnosis (Fourth in a series).
5. The Exfoliative Cytologic Method in the Diagnosis of Gastric Cancer.
6. What Is Cancer? (Film for nurses).

These films are shipped both ways at the expense of the Society and are available to any meeting of physicians or for individual viewing.

SERVICE

The basic policy adopted by the Oklahoma Division of the American Cancer Society at its inception is "Every doctor's office a detection center." The Society's Service Program emphasizes particularly care for the indigent and medically indigent cancer patient. It has also been a policy of the Oklahoma Division, since its inception, that the Division does not pay hospital or doctor's fees. The services of the Division are made available to the medically indigent patient of any licensed physician in Oklahoma, and inquiry in behalf of these patients is made either to the County Commander or directly to the Division Office in Oklahoma City.

The Service Program includes the following:

1. The Oklahoma Division maintains three Cancer Tumor Clinics at the University Hospital in Oklahoma City, St. Johns Hospital in Tulsa, and the Muskogee General Hospital in Muskogee. Doctors anywhere in the State are privileged to send patients to any one of these clinics. The services of these clinics are for the indigent cancer patients.

2. The Oklahoma Division maintains a Cancer Mobile Detection Clinic which goes into every county in the State, only upon request of the County Medical Society and/or the request of any group of local physicians.

3. The Oklahoma Division furnishes pain relieving drugs to indigent cancer patients, upon request of the attending physician and the County Commander, pro-

vided there are no county funds available for this purpose.

4. Cancer dressings, which are made by the Women's Field Army of the Cancer Society, will be furnished in any quantity and any size to any indigent cancer patient. If such dressings are not available from the local County Commander, they will be furnished from the State Office, express prepaid. It is impressive to kuow that if the average cancer sufferer were to buy his own dressings, it would cost him an average of $45 to $50 per month.

5. Upon request of the attending physician, the Oklahoma Division furuishes the drug *Testosterone* for the indigent caucer patient, direct from this office. This is a very expensive drug and one that is extremely helpful to the patient with cancer of the breast. Testosterone is shipped from the Division Office at the physician's request. I t should not be purchased locally.

6. The Oklahoma Division will pay transportation of the indigent cancer patient to either the University Hospital, St. Johns Hospital, or the Muskogee General Hospital, upon request of the Commander and the local doctor.

7. The Oklahoma Division will pay board and room for the indigent cancer patient while receiving treatment in any of the above mentioned clinics.

8. The Oklahoma Division each year budgets a small "Emergency Fund" for immediate financial aid, upon recommendatiou of the local physician and the Couuty Commander.

RESEARCH

One-fourth of all the funds donated by the public to the American Cancer Society goes into cancer research. Tweuty-five cents of every dollar received is earmarked for cancer research. In spite of the increased interest and support on the part of the public, expausion of research activities and training of scieutific manpower in this country are being held back through lack of funds. While much can be done in the fields of education and service to save the lives of many who now die unnecessarily, the search for the ultimate cure for cancer is the basic aim of the American Cancer Society.

To that end, the followiug has been allocated to the furtherance of research in our own State from American Cancer Society funds:

1948-1949

INSTITUTIONS	*Institutional Total*	*Yearly Total*
University of Oklahoma		
Dr. J. M. Thuringer	$ 3,675.00	
Dr. Mark Everett	11,400.00	
		$15,075.00
Oklahoma Medical Research Institute — For cancer research from funds of the Oklahoma Division	30,000.00	
		$ 30,000.00

1949-1950

University of Oklahoma		
Dr. J. M. Thuringer	Extension of time only.	
Dr. Mark R. Everett	11,400.00	
Dr. H. C. Hopps	5,000.00	
Dr. K. M. Richter	3,134.00	
		$ 19,534.00

1950-1951

University of Oklahoma		
Dr. Mark R. Everett	Extension of time only.	
Dr. H. C. Hopps	5,000.00	
Dr. K. M. Richter	3,134.00	
	$ 8,134.00	
Oklahoma Medical Research Institute		
Dr. Charles D. Kochakian (Transferred from Yale Univ.)	2,065.03	
Dr. Charles D. Kochakian (Transferred from Yale Univ.)	2,742.49	
	4,807.52	
		$ 12,941.52

1951-1952

University of Oklahoma		
Dr. K. M. Richter	5,000.00	
Dr. H. C. Hopps	Extension of ime only.	
	5,000.00	
Oklahoma Medical Research Institute		
Dr. Charles D. Kochakian	7,106.00	
Drs. Reifenstein & Kochakian	30,000.00	
	37,106.00	
		$ 42,106.00

1952-1953

University of Oklahoma		
Dr. K. M. Richter	Extension of time only.	
Dr. M. R. Shetlar	4,940.00	
	4,940.00	
Oklahoma Medical Research Institute		
Drs. Reifenstein & Kochakian	25,000.00	
		$ 29,940.00
GRAND TOTAL		$149,596.52

This means that a grand total of $149,596.52 has been contributed to cancer research in Oklahoma from the Oklahoma Division and the American Cancer Society funds.

OKLAHOMA STATE HEART ASSOCIATION

An Affiliate of the American Heart Association

825 N.E. 13th Street — Oklahoma City, Okla. — Telephone CE 2-4947

HUGH G. PAYNE, Executive Secretary (Volunteer)

Purpose

The purpose of the association is to study, disseminate, and apply knowledge concerniug the normal heart and circulation, and the causes, diagnosis, prevention, and treatment of disorders of the circulation and diseases of the heart, blood vessels and lymph vessels; the development and application of measures that will prevent such disorders and diseases.

Function

The method of achieving this purpose is through the

sponsoring of medical research and an educational program designed for both professional and lay personnel.

In Oklahoma, the State Association has adopted a policy whereby one-third of all the money raised annually by the Association and retained in Oklahoma, goes to the Oklahoma Medical Research Foundation to support the Cardiology Research Section. During the past two years, this has amounted to $26,360.

Of the money raised in Oklahoma, one-fourth goes to the American Heart Association. Of that sum, one-half is set aside for research in cardiology throughout the nation. During the past two years, Oklahoma has received $8,400 for heart disease research from the American Heart Association.

Organization

The Association is non-profit and membership includes all those who have shown an interest in this health agency by contributing. Management rests with a Board of Directors consisting of uot less than 30 or more than 40 members who serve staggered three-year terms. Officers consist of a President, President-Elect, Vice President, Secretary and Treasurer, who are elected annually.

The Board of Directors annually elects an Executive Committee of not more than 12 Directors, including the President, President-Elect and the Vice-President of the Association and Chairman of the Budget Committee.

Activities

The major emphasis of the Association's program is to sponsor competent research in the field of cardiology.

In addition, the educational phase of the program consists of professional education, including preparation and showing of exhibits, professional meetings sponsored in cooperation with other agencies such as low sodium diet workshops and symposiums on chronic illness, and maintenance of a speakers' bureau on this subject.

The second phase of the educational program is designed for the general public and includes exhibits at functions such as the state fair and farm and home week; talks on heart disease; showing of motion pictures; distribution of printed material, and news stories.

The third phase of the educational program involves community service, including assistance in establishing cardiovascular clinics at the University Hospital in Oklahoma City and Hillcrest and St. Johns Hospitals in Tulsa; the rheumatic fever study involving records of 1,200 rheumatic fever patients that have been carried by the Crippled Childrens Commission, and a study of the cardiac in industry problem.

THE NATIONAL FOUNDATION FOR INFANTILE PARALYSIS, INC.

1141 N. Robinson Telephone FO 5-8461

CARL C. THOMPSON,
State Representative—Western Oklahoma
Oklahoma City, Oklahoma

BILL EPPERSON,
State Representative — Eastern Oklahoma
Oklahoma City, Oklahoma

The purpose of the Foundation is to lead, direct and unify the fight against infantile paralysis. Activities include research, education, epidemic aid, and patient care. Grants are made to institutions for research in the transmission, prevention, and cure of infantile paralysis, as well as in improved treatment methods. The educational program provides information to professional aud lay groups, and scholarships and fellowships for training of doctors, nurses, physical therapists in a variety of specialized fields including virology, orthopedic surgery, pediatries, physical medicine, orthopedic nursing, physical therapy, etc. In cooperation with representatives of health, welfare, and social ageucies, epidemic preparedness programs are conducted to help communities meet outbreaks. Epidemic aid such as money, equipment, personnel, and professional consultation is available to communities. All programs of the National Fouudation are made possible through contributions to the MARCH OF DIMES.

It is the policy cf of the National Foundation for Infantile Paralysis NOT to recommend any doctor or hospital, but strictly for information purposes, the following hospitals in Oklahoma accepted and treated polio during 1952:

1. Valley View Hospitals, Ada, Oklahoma
2. Alva General Hospital, Alva, Oklahoma
3. Children's Convalescent Hospital, Bethany, Oklahoma
4. Community Hospital, Elk City, Oklahoma
5. St. Mary's Hospital, Enid, Oklahoma
6. Guymon Municipal Hospital, Guymon, Oklahoma
7. Benedictine Heights Hospital, Guthrie, Oklahoma
8. Comanche County Memorial Hospital, Lawton, Oklahoma
9. Bone and Joint Hospital, Oklahoma City, Oklahoma
10. University Hospital, Oklahoma City, Oklahoma
11. Muskogee General Hospital, Muskogee, Oklahoma
12. LeFlore County Memorial Hospital, Poteau, Oklahoma
13. Stillwater Municipal Hospital, Stillwater, Oklahoma
14. Hillcrest Memorial Hospital, Tulsa, Oklahoma
15. Junior League Children's Hospital, Tulsa, Oklahoma
16. St. John's Hospital, Tulsa, Oklahoma

All these hospitals do not normally accept polio, thus it is strongly urged that admission be arranged by telephone BEFORE sending a patient to any of them.

Since there are fewer hospitals than doctors concerued with the polio problem, continual contact is maintained with the hospitals aud they can advise the patient whom to contact in their home county to receive financial assistance if needed.

Briefly, the policy of the National Foundation for Infantile Paralysis in rendering financial assistance is: "If the standard of living of the family involved will be materially lowered by the expense of giving the patient the best available medical care, then the National Foundation should pay that part of the expense which works a hardship on the family." All patient care assistance is rendered through the local County Chapter.

The referral of polio patients to the Georgia Warm Springs Foundation is not ordinarily recommended because necessary treatment in all except the most unusual cases can be provided with considerably lower expense for hospitalization and transportation when the treatment is provided through facilities available in the state. Patients having unusual residual conditions may be referred to Georgia Warm Springs by the

attending physician communicating with the Medical Director, giving the diagnosis and history as well as his recommendations. The medical staff at Georgia Warm Springs will review the case and, on the basis of their findings, will admit the patient when space is available. It is to the advantage of all concerned to hold the number of cases referred to Warm Springs to a minimum, since the greatly increased expense must be borne either by th family or by the National Foundation.

Any Oklahoma physician can feel perfectly safe in arranging hospitalization for a polio patient and depending on the family and hospital to make financial arrangements later.

OKLAHOMA MEDICAL RESEARCH FOUNDATION

825 Northeast 13 Street

Oklahoma City, Okla. — Telephone CE 2-9527

Hugh G. Payne, General Manager

I HISTORICAL BACKGROUND

In 1944 the Oklahoma Medical Research Foundation was only an idea in the thinking of a small group of Alumni of the University of Oklahoma School of Medicine and other interested physicians.

In 1945 the idea developed from the talking stage into a plan for a medical research foundation to be formed to provide funds to promote, develop, construct and maintain a medical research institute.

1946 saw the plan become an organization. The Alumni of the Oklahoma University School of Medicine provided funds for a survey of the State to determine the public's interest in supporting the Foundation. On August 23, 1946, the Oklahoma Medical Research Foundation was incorporated under the laws of the State.

II UNIFIED EFFORT OF ALLIED PROFESSIONAL GROUPS

Never in the history of this nation or any other nation as far as Foundation officials are able to ascertain has a great medical research center come into being through the unified effort of all legitimate allied professional healing groups. Early in 1947 the Doctors of Medicine set a goal of providing one million dollars within that professional group for the operation and maintenance of the Foundation. The campaign organization was set up which provided for a state chairman, district chairmen, county and community chairmen. As a result of this action, nearly 700 doctors have pledged close to $800,000 cash, and with the gift of income producing property, this total is well over $1,000,000.

In September 1947 the Oklahoma State Dental Association officially approved participation of Dentistry in the campaign research program and set a goal of $225,000 to be raised among the Dental Profession.

The Oklahoma State Pharmaceutical Association requested the Foundation officials to allow their association to accept its full share of the founding program; a goal of $300,000 was set, and the pharmacists have worked hard to reach their goal.

In November 1947 the State Nurses Association unanimously adopted a resolution providing a research fund of at least $50,000 among the nurses of the State toward the Foundation's support. This group organized its campaign and in a very short time the Nurses' Research fund of $50,000 had been reached and oversubscribed.

Certainly Oklahoma is setting an enviable record toward providing ways and means for the progress of Medical Science. Without the leadership of the Doctors of Medicine, this unified effort would not have been possible.

III ADMINISTRATIVE AND OPERATIONAL POLICIES

1. Characterization

A non-profit corporation.

2. Purposes (General)

To promote educational objectives by encouraging, fostering and conducting scientific investigations in medicine in cooperation with, or independently of, the School of Medicine of the University of Oklahoma and in cooperation with the faculty, staff and students thereof and those associated therewith, or independent of such faculty, staff and students and in connection therewith and incidental to such purpose.

A. To foster and encourage education and learning in the medical sciences, both pure and applied, both in connection with the School of Medicine and independently thereof;

B. To provide or assist in providing the means and machinery by which scientific discoveries and processes may be developed, applied and patented and the medical uses thereof determined commercially, and by which such utilization or disposition may be made of such discoveries and processes, and patent rights or interests therein, as may tend to stimulate and promote and provide funds for further scientific investigation and research;

C. To train persons for the conduct of such investigations and research and to acquire and disseminate knowledge in relation thereto;

D. To provide a research institute building to facilitate the advancement of both the clinical and the fundamental medical sciences, and to equip and maintain said institute through private contributions, grants and endowments, and to supply the necessary funds and money in endowments or grants;

E. To receive by gift, devise, bequest or otherwise, any money or property, either absolutely or in trust, to be used, either the principal or income therefrom, as may be directed, in the furtherance of any of the above mentioned purposes or any other purpose within its corporate powers;

F. To own, acquire, hold and manage such real property or personal property as may be reasonably necessary for the business and object of such association;

G. To make grants or gifts of money or property to hospitals, schools or other public or private institutions whose purposes may be similar to the purpose herein contained; to aid in paying the salaries of teachers, staff employees, doctors, nurses, or other personnel of such institutions; to give or grant such funds or property for the purchase of equipment, the defraying of expenses, or for any other purpose not inconsistent with the purpose herein contained,

H. To provide space and adequate facilities for the special study and treatment of patients;

1. To experiment upon, test, promote and develop the scientific and commercial value of inventions, discoveries and processes.

J. To prosecute and aid in the prosecution of applications for patents and to obtain patents, both foreign and domestic; and of rights, licenes and interests in processes and patents; and to accept gifts or grants of money, patents, pat-

ent rights or other property, subject to such conditions or trusts as may be attached thereto or imposed thereon with respect to payment of royalties, application of income or proceeds, or otherwise, and to obligate itself to perform and execute any and all such conditions or trusts.

* * * * It is the purpose and intent of this coporation to cooperate with the School of Medicine of the University of Oklahoma or any other agencies which involve the teaching of medicine or allied subjects, or involve research therein, to the fullest extent for the mutual benefit of such school or agencies and this corporation shall be under the exclusive control and direction of the directors of this corporation.

Membership

Any person who contributes to the support of the Foundation is a member of the organization.

The usual physician membership consists of a $1,000 pledge which may be payable over as long as a 10-year period.

Officers

The officers of the Foundation consist of six—President, Vice-President, Secretary, Treasurer, Chairman of the Executive Committtee and General Manager of the Foundation. All officers except Chairman of the Executive Committee are elected by the Board of Directors, representing the membership, for a term of one year. -The Chairman of the Executive Committee is nominated by the Executive Committee and approved by the Board of Directors. Any officer is eligible to succeed himself.

Meetings

The annual meeting of members of the Foundation shall be in the fall of each year. -The time and place of the meeting shall be established by the Executive Committee which shall be required to give thirty days' notice of such meeting, by mail, to all members. Notice to local units shall be considered the equivalent of notice to the Unit Members.

Board of Directors

There shall be a Board of Directors of not less than 20, ner more than 40, elected from the membership of the Foundation and or as hereinafter provided for a term of three years, approximately one-third to be elected each year by and from the membership of the Foundation. Any Director shall be considered eligible for election to succeed himself. Directors shall be of three classifications: Officers, Representative Directors and Directors-at-Large.

EXECUTIVE COMMITTEE

The Executive Committee shall consist of not less than 10 nor more than 28 members.

It shall be the duty of the Executive Committee to exercise, when the Board of Directors is not in session, any and all powers of the Board of Directors which lawfully may be delegated, including the power to execute legal instruments in the name of the Foundation, and to perform such other duties as may be assigned to it by the bylaws.

The following specific duties are assigned:

* * * * * To prepare an annual budget for the Foundation as provided in Section 5 (D), Article VII; * * * * * To supervise the activities of the General Manager as provided in Article V, Section 6; To supervise the activities of the Director of the Rehearch Institute and Hospital as provided in Article V, Section 7; * * * * * To act upon recommendation from the Director of the Research Institute and Hospital regarding funds for scientific purposes; to appropriate the funds of the Foundation as deemed advisable and supervise their expenditures; * * * *.

STANDING COMMITTEES

Inter-Allied Professional Committee.

It shall be the duty of this committee to foster, organize and promote inter-professional relationships, (a) for the good of the Foundation, (b) for the enlightenment of the individual members of the organization involved, (c) to encourage closer relationships in raising the standards of medicine, dentistry and pharmacy for the good of mankind, (d) to serve as arbitrators ou problems involving the component organizations.

Budget Committee.

The duties of the Budget Committee shall be:

A. To render opinions on financial matters as referred to the Committee by the Executive Committee.

B. To make definite recommendations to the Executive Committee in relation to specific financial matters when requested to do so by the Board of Directors or the Executive Committee.

C. To invest, after careful consideration, any surplus monies or holdings of the Foundation when requested to do so by the Executive Committee.

D. To pass upon the advisability of accepting bequests, grants and gifts which may be proffered the Foundation subject to restrictions or qualification.

Bequest Committee.

The duties of the Bequest Committee shall be:

A. To formulate and prosecute educational plans for the purpose of informing the legal profession in relation to the Foundation's need for all types of bequests and eudowments.

B. To prepare and distribute necessary legal forms for use by clients naming the Foundation as beneficiary or recipients of bequests and endowments.

C. To actively engage in contacting prospective donors in relation to bequests.

General Research Advisory Board.

Duties of General Research Advisory Board shall be:

A. To act as consultant and advisory group to the Director of the Research Institute and Hospital in all matters referred by him to the General Research Advisory Board concerning the planning, operation, and administration of the scientific activities of the Foundation and the Research Institute and Hospital.

B. To review all applications for research projects, and to make recommendations for approval or disapproval of such projects, and to make recommendations, in priority form, relative to the financing of the approved projects; these recommendations to be made in writing to the Director of the Research Institute and Hospital for transmittal to the Executive Committee.

C. To assume any other appropriate duties or responsibilities assigned to the General Research Advisory Board by the Director of the Research Institute and Hospital.

D. To make recommendations to the Director of the Research Institute and Hospital for the good of the Foundation.

E. To make a yearly evaluation report regarding the over-all research program to the Director of the Research Institute and Hospital.

National Advisory Board.

The duties of the National Advisory Board shall be:

A. To act as a consultant and advisory group to the Director of the Research Institute and Hospital in all matters referred by him to the National Advisory Board concerning the planning, operation, and administration of the scientific activities of the Foundation and the Research Institute and Hospital.

B. To assume any other appropriate duties or responsibilities assigned to the National Advisory Board by the Director of the Research Institute and Hospital.

C. To make recommendations to the Director of the Research Institute and Hospital for the good of the Foundation.

D. To make a yearly evaluation report regarding the over-all research program to the Director of the Research Institute and Hospital.

Subcommittee on Dental Research.

The duties of the Subcommittee on Dental Research shall be:

A. To advise on dental research projects and submit to the Foundation General Research Advisory Board definite written recommendations as to the disposal of such projects.

B. To encourage the development of research projects by members of their own profession.

C. To interpret to members of the Dental Profession any advances in dental research.

D. To arrange, foster and promote seminars and conferences in conjunction with the Director of the Research Institute and Hospital, to be held under the auspices of the Research Institute and Hospital for the purpose of keeping the members of the Dental Profession informed concerning the scientific developments in the practice of dentistry and in the field of dental research.

E. To make recommendations to the General Research Advisory Board on matters for the good of the Foundation.

Subcommittees on Pharmaceutical Research.

The duties of the Subcommittee on Pharmaceutical Research shall be:

A. To advise on pharmaceutical research projects and submit to the General Research Advisory Board definite written recommendations as to the disposal of such projects.

B. To formulate, foster and promote plans whereby the members of the profession with scientific research ability are encouraged to submit ideas on research for consideration.

C. To arrange seminars and conferences in conjunction with the Director of the Research Institute and Research Hospital to be held under the auspices of the Research Institute and Hospital for the purpose of enlightenment in relation to advances in the field of Pharmacy and Pharmacodynamics.

D. To make recommendations to the General Research Advisory Board on matters for the good of the Foundation.

Subcommittee on Medical Research.

The duties of the Subcommittee on Medical Research shall be:

A. To advise on medical research projects and submit to the Foundation General Research Advisory Board definite written recommendations as to the disposal of such projects.

B. To encourage the development of research projects by members of their own profession.

C. To interpret to members of the Medical Profession any advances in medical research.

D. To arrange, foster and promote seminars and conferences in conjunction with the Director of the Research Institute and Hospital for the purpose of keeping the members of the Medical Profession informed concerning the scientific developments in the practice of medicine and in the field of medical research.

E. To make recommendations to the Research Committee on matters for the good of the Foundation.

Subcommittee on Nursing Research.

The duties of the Subcommittee on Nursing Research shall be:

A. To advise on nursing research projects and submit to the General Research Advisory Board definite recommendations as to the disposal of such projects.

B. To encourage the development of research projects by members of their own profession.

C. To interpret to members of the Nursing Profession any advances in nursing research.

D. To arrange in conjunction with the Director of the Research Institute and Research Hospital seminars and conferences to be held under the auspices of the Research Institute and Hospital for the purpose of keeping the members of the profession of nursing informed concerning the scientific developments in the practice of nursing and in the field of nursing research.

E. To make recommendations to the General Research Committee on matters for the good of the Foundation.

IV PROGRAM OF RESEARCH

The general inclusive field of study is geriatrics. The Foundation's scientific staff will do both clinical and basic research involving laboratory studies, experimentation using animals and the operation of a special research hospital.

The three major sections of research will include oncology, cardiology, and metabolic disturbances.

V 1952 STATUS

With $2,443,000 as the total amount pledged, the Foundation has been able to operate since 1946.

Activities include the construction of a moderuistic building housing excellent facilities for all types of research and the securing of a scieutific staff which now numbers about 50 people.

Research in the basic field has been under way for nearly two years, with primary emphasis on the preparation of steroid hormones and studies concerning the effect of hormones on various body tissues.

The clinical program began in September with the opening of the 22-bed research hospital, where the first patients included two cancer, one bone disease, aud one heart cases for research purposes.

The Foundation has become well euough known that several people have named it as beneficiary in their wills, and the Fouudatiou is already receiving fiuancial support from two wills, from a trust fund, and it is receiving income from the gift of a sanitarium, made by Dr. Coyne H. Campbell of Oklahoma City. This property, which is still operated by Doctor Campbell, has brought several thousand dollars annually to the Foundation.

Those in charge of operation of the Foundation, who are outstauding professional and business leaders of this area, are confident that with the continued interest and support of the physicians and the lay citizens of the state, the Foundation will be able to make important contributions to medical knowledge, through the years.

OKLAHOMA TUBERCULOSIS ASSOCIATION

Constituent of the National Tuberculosis Association

22 N.W. 6th St. — P.O. Box 1661

Oklahoma City, Oklahoma Telephone CEntral 2-1400

CARL PUCKETT, M.D., Managing Director

Oklahoma Division of the National Tuberculosis Association is financed by the sale of Christmas Seals. The aim is eradication of tuberculosis.

Program includes prevention of tuberculosis through health education, control through case finding and diagnostic clinics, and leadership in promotion for care of patients by government through county health departments and state sanatoriums. Each county of the state has its own association operating under supervision of the state association. Local programs stress health education and organization under direction of executive secretaries where funds permit.

Projects include furnishing educational supplies to physicians, county health departments and schools. Monthly bulletins on tuberculosis are mailed to physicians, and tuberculin sent on request. The association provides a counsel service for patients and contacts and makes the referrals to physicians or established clinics. Literature, posters and moving pictures are used by the health education branch of the association in teaching.

Most x-ray films used in clinics throughout the state are provided from county Christmas Seal funds in cooperation with health departments.

The State Association gives financial cooperation in mass x-ray surveys for discovery of tuberculosis, and furnishes public health nursing, chest clinics and follow-up in counties without health departments. Pamphlets for instruction and guidance of tuberculosis patients and contacts and literature for the public on prevention of tuberculosis are provided through county health departments or county tuberculosis associations.

Tuberculosis associations promote standard public health departments in keeping with methods approved by organized medicine; the program conforms to the plan outlined in Section Eight on "Health Education" of the Program of the American Medical Association for the Advancement of Medicine and Public Health. These funds are not used to finance responsibilities of government except during periods of demonstration. The aim is promotion of sound governmental procedures in meeting the many angles of the problem of tuberculosis.

TO ALL MY PATIENTS

I invite you to discuss frankly with me any questions regarding my services or my fees.
The best medical service is based on a friendly, mutual understanding between doctor and patient.

GOVERNMENTAL HEALTH AND WELFARE AGENCIES

THE UNIVERSITY OF OKLAHOMA SCHOOL OF MEDICINE AND UNIVERSITY HOSPITALS

800 Northeast 13th Street, Oklahoma City, Okla. Telephone RE 6-1511

MARK R. EVERETT, Ph.D., Dean
School of Medicine and Superintendent of Hospitals

ROBERT C. LOWE, M.D. Medical Director
, Uuiversity Hospitals

The maintenance and operation of the University Hospitals in Oklahoma City are jnstified on the basis of medical education. The primary fnnctious of the Hospitals relate to the instruction of undergraduate stndents in medicine and in nnrsing, and to the training of graduate students in medicine (internes, assistant residents, residents, and fellows). Opportnnities are provided, in addition, for the training of persons in certain auxiliary fields, as medical technology, X-ray technology, and dietetics. Obviously, in fulfilling these fnnctions, a significant service factor develops; bnt it is emphasized that the service factor, important as it is recognized to be, is a function secondary to the primary educational obligation.

The service factor in the teaching hospital requires certain development frequently not understood, sometimes misnnderstood or misinterpreted by those who aro unaware of the educational obligations or who are interested in no other fnnction than the service factor, so that this statement is presented in an effort to clarify certain relevant points in order that practicing physicians of Oklahoma may interpret to their patients the opportunities for and the limitations of hospital care offered in the University Hospitals.

As the Hospitals are set up, certain types of patients are admitted through agencies set np by statute, by following procednres established by the agencies or by statnte (Crippled Children's Commission, State Veterans Department). The limitations of geographic location of the physical plant, of the budget for maintenance and operations, of standards in medical care, in medical education, and in nnrsing education, and of personnel, also operate to make it possible only to render certain services. (There are avai'able no beds for the care of psychiatric patients, no beds for the care of tnberenlosis patients, no beds for the care of patients, adnlts, adolescent, or child, ill with any of the usual communicable di'ea'es except as these are especially set up and provided for to meet an emergency, as in an outbreak of acnte anterior poliomyelitis, for examp e. For obvious reasons, the care of obstetrical patients under ordinary circum:tances is limited to those of residence in a zone of short ra'lins aronnd Oklahoma City. Similarly, emergency accident admissions are limited by various factors including transportation, physical facilities, et cetera.)

Before presenting rather detailed information relating to the procednres involved in hospital patients admission, it seems appropriate to emphasize the point that it is highly important that arrangements for the admission be made in advance (by telephone in emergencies, by mail if time permits) of the patient's appearance at the Hospitals for admission, by direct commnnication with the Office of the Director of Out-Patient Department attention Admissions Office, University Hospitals, 800 N.E. 13th Street, Oklahoma City 4, telephone: Oklahoma City RE 6-1511.

The procedure related to the admission of patients to the Oklahoma Hospital for Crippled Children, to the University Hospital, and to the Out-Patient Clinics are ontlined below.

On the basis of the uew Oklahoma Crippled Children's Act (HB 144), provisiou is made for the medical care of unmarried dependent children nnder twenty-one years of age. Under this act the Oklahoma Hospital for Crippled Children, as well as other hospitals of the state accredited by the Crippled Children's Commission, are required or authorized to care for children whose families cannot pay for the necessary medical and surgical treatment.

The appropriate application forms are obtainable from the County Jndge or the local Department of Public Welfare. They should be filled in by the local examining physician (private or county health officer), signed by the responsible parent or guardian and signed by either the County Jndge or the Connty Welfare Director. The application shonld then be submitted to the Oklahoma Commission for Crippled Children.

When the local physician appraises the condition an emergency, authorization for immediate hospitalization can be secnred by telephone communication with the Admitting Office. The appropriate papers are then brought along with the patient. Is is always uecessary that the responsible parent or guardian accompany the child to the Hospital. In the case of smaller children it is necessary that someone familiar with the onset and conrse of the illness accompany the child to give the historic facts. The local physician's own observations will be of great help in most instances. In addition, specific permission anthorizing appropriate operative procedures is necessary.

Since the operating capacity of the hospital is not unlimited, the Staff and the Admitting Department have the responsibility of selecting patients to be admitted to the In-Patient Services. In the iuterest of carrying ont this responsibility the iuitial stndy of each patient is carried out in the Clinics. It is for this reasou that the patient is given an appointment to the Clinics whenever this is possible without jeopardy to him or her. If the home physician or health officer feels that the patient presents an emergency problem, arrangements should be made by telephone commnnication with the Admitting Office. Iu some instauces these arrangements will necessarily be delayed or may not be possible within the required time. In the latter case suggestions as to possible arrangements elsewhere will be made.

The primary qualifications for admission include the provisions that: (1) the patient and his illness fit

into the undergraduate medical teaching program of the School of Medicine. (2) active medical or surgical treatmeut is necessary and there is a good prospect of aid to the patient. It is not possible to admit patients who require only nursing care, nor to admit those with chronic illnesses in which the possibilities or treatment are recognized to be problematical. It is always necessary for the Hospitals to have patients whose problems are of teaching value. This requires that there be variation in clinical problems and an avoidauce of overweighting of services.

The more immediate the need the earlier the patient will be admitted. It is only by the selection of pateints that the service and teaching functions of the Hospitals can be carried out, and at the same time avoid, insofar as possible, the disappointmeut of expectations that caunot be fulfilled.

The Main (University) Hospital is set up for the care of indigent adult patients. The authorization for such care is obtained from the County Commissioners. The local physician or health officer wishing to refer a patient to the Hospital cau facilitate admission materially by providing all pertinent information requested in the County forms (Application for Admission to the University Hospital or Clinics). These forms are available from the County Commissioners' Offices. Upon completion they should be mailed to the Admitting Office of the University Hospital. With the aid of the social and medical information outlined therein, the necessary arrangements will be made and the patient will be notified as to the day and time that the clinic to which he should come meets. It will be recoguized that this appointment method is necessary when it is understood that between 40 and 50 thousand patients are seen in the University Hospital's Out-Patient Clinics each year.

The Clinics of the Hospitals have three service functions: (1) the diagnostic study of patients referred by the attending physician, (2) the ambulatory care and follow-up of patients when such care is feasible, and (3) the selection of patients for hospitalization. All of these functions form the basis for a very important aspect of the teaching of students of medicine in the third and fourth years of the course. It is the nearest approach to actual office practice that can be offered the uudergraduate student of medicine in the institution.

Due to limited personnel, the large patient load, and the teaching requirements placed on the Staff (primarily voluntary), it is not always possible to send to the attending physician detailed summaries of the finding and treatment in each patient. All inquiries can and will be answered fully, so the referriug physician should not hesitate to ask for them if he is particularly interested. Whenever possible, and always when requested, the patient will be referred back to his home physician with the results of the study and recommendations for continuing treatment.

The Out-Patient Clinics do not have a pharmacy to fill prescriptions. The Social Service will help in making arrangements with the County Commissioners to supply medicines as recommended by the Staff. This is true also in the case of special diet requirements that cannot be met by the patient himself. The referring physician, likewise, should enlist the Commissioner's aid.

Because of a total lack of facilities in the University Hospitals for the care of such patients, in certain types of clinical problems (such as tuberculosis), the patient will be referred back to the attending physician and local health department to arrange for care in one of the State Sanatoria. The same course is followed in psychiatric disturbances requiring institutionalization. The limited time available from the psychiatric staff, the large number of cases, and the time required for psychotherapy, make it impossible for the Neuro-psychiatric Clinic to offer anything but diagnostic and short term simple therapeutic aid.

When hospitalization in the University Hospitals is recommended every effort is made to arrange for it on the basis of the Staff's impression of the patient's needs. Real emergencies are admitted without delay. Occasionally it is necessary to arrange for hospitalization elsewhere. If the problem is not emergent and a bed is not available, the patient will be sent home and notified at a later date to return for admission to the Hospital.

For the information of physicians and of their patieuts, it seems appropriate to invite attention to certain other miscellaneous points:

(1) The University Hospitals have no facilities or funds through which the transportation of patients from home to hospital or from hospital to home may be provided. In some instances (crippled children, cancerous patients, poliomyelitic patients), local agencies may be able to provide transportation thorugh specific arrangements with the interested and responsible group (Crippled Children's Commission, Local Chapter of the Oklahoma Division of the American Cancer Society, Local Chapter of the National Foundation for Infantile Paralysis).

(2) Certain medicolegal aspects of the care of minors or children make it necessary that all patients under the age of 21 years be accompanied by parents or guardians.

(3) When the attending physician sends the patient in to the University Hospitals for admission or for Out-Patient Clinic care, it is expected that he provide the Admitting Office with social data and other relevant information, including at least a summary of history, of physical and clinical findings of impression or diagnosis, and of treatment instituted. The Hospitals, in return, will make every effort to supply the physician with a summary of the findings, of diagnosis, of treatment, and of recommendations as soon as possible. (There have been many complaints of the Hospitals' not providing the patient's physician with such a report, and they probably have been justified fully in many instances. Two factors operate to give rise to such delays: (a) the attending staff physician in the Uuiversity Hospitals is nearly always a voluntary teaching staff member whose time is at a premium, and (b) inadequacy of secretarial service delays getting letters out after dictation).

The University Hospitals, even if they were doubled in size and adequately financed for maintenance and operation, cannot possibly render service to all indigent Oklahomans needing hospital care. The teaching needs of the Hospitals, both in medicine and in nursing, act to limit still further the opportunities of serving patients. It is the hope and ambition of the Hospitals' staffs to render the maximum of service, however, both as to quality and quantity, to the best of its ability within the limits of function, responsibility, fuuds available for operation and maintenance, and physical plant. Mutual understanding of problems involved should permit more effective service.

PATRONIZE DIRECTORY ADVERTISERS

STATE DEPARTMENT OF HEALTH

3400 North Eastern Oklahoma City, Okla.

Telephone GArfield 7-2421

GRADY F. MATHEWS, M.D., Commissioner of Health

The Oklahoma State Department of Health is created by the Constitutiou and the State Board of Health was created by statute in 1945. The State Board of Health is authorized to adopt rules and regulations for its own government. They also shall appoint the Commissioner of Health who is the Executive Officer of the State Department of Health. For efficiency in administration, the State Department of Health is separated into divisions: Chronic Diseases, Epidemiology, Fiscal Services and Personnel, Health Education, Hospital Licensure and Construction, Laboratories, Local Health Services, Maternal and Child Health, Mental Hygiene, Preventive Dentistry, Public Health Nursing, Sanitation and Public Health Engineeriug, Statistics and Vital Records, Tuberculosis Control, and Venereal Disease Control.

The State Department of Health serves in an advisory and consultant capacity to the various local health departments in promoting local programs. Because of the highly technical nature of some services, such as epidemiology, vital statistics, laboratory and some engineering, these are offered on a statewide basis rather than through local health departments.

CHRONIC DISESASE CONTROL

This division administers the heart disease, diabetes and cancer control programs.

Cancer was made a reportable disease in 1947. Statistical studies are made from data from morbidity reports and death certificates.

The division cooperates with the University Hospital in the provision of personnel and equipment for a cancer diagnostic clinic in Oklahoma City. A second clinic in cooperation with the County Medical Society and the local health department is in operation in Tulsa at St. Johns Hospital. A third clinic in cooperation with the County Medical Society and the local health department is in operation in Muskogee at the local health department.

Hospitalization for diagnostic purposes is available to indigent persons at the three places for a period not to exceed three days.

In cooperation with the University of Oklahoma School of Medicine, this division provides postgraduate courses in cancer, diabetes, and cardiology for private physicians throughout the state.

Educational films, designed to aid the physician in the diagnosis of various types of cancers, are available on a loan basis from the State Department of Health film library.

The division cooperates with the University Hospital and the Crippled Children's Hospital in the provision of personnel aud equipment for diagnostic heart clinics in Oklahoma City. Certain personnel and equipment are also provided in cooperation with the County Medical Society and the Heart Association in Tulsa for the operation of diagnostic heart clinics at the Variety Center and the Community Welfare Building.

This division also provides consultative service to personnel in local health departments who conduct diabetes detection programs in cooperation with local diabetes commoittees. It provides inservice training in methods of diabetes detection and control to health department personnel and members of allied professions. In addition, the active participation of responsible civic organizations is stimulated through demonstrations of actual diabetes screening procedures.

EPIDEMIOLOGY

This division has as its function the work of coordinating and directing efforts toward the control of communicable disease within the state. As a basis for control procedures the State Department of Health has adopted the 1945 revised rules and regulations recommended by the American Public Health Association and published in their manual "The Control of Communicable Diseases in Man."

Reportable and Quarantinable Diseases

Cholera, diphtheria (including membraneous croup), plague (including bubonic, septic, and pneumonic), poliomyelitis, scarlet fever (scarletina, scarlet rash), smallpox (variola), epidemic cerebro spinal meningitis.

Reportable and Isolated Diseases

Anthrax, chickenpox, dysentery, bacillary, encephalitis, infectious (lethargic and nonlethargic), favus, glanders, gonorrhea, influenza, measles, meningococcus meningitis (cerebro-spinal fever), mumps, paratyphoid fever, psittacosis, septic sore throat, trachoma, tuberculosis (pulmonary), typhoid fever, whooping cough, yellow fever.

Reportable Diseases

Dengue, conjunctivitis, acute infectious (of newborn, not including trachoma), dysentery, amebic, hookworm disease, malaria, rabies, Rocky Mountain spotted fever, tetauus, trichinosis, tuberculosis (other than pulmonary), tularemia, typhus fever, undulant fever (brucellosis), filariasis, ascariasis, hemorrhagic jaundice (spirochetosis icterohemorrhagic, Weil's disease), impetigo, rat bite fever (sodoku), relapsing fever, ringworm, scabies (itch), Vincent's infection (Vincent's angina), trench mouth, yaws, botulism, food infections and poisonings, pellagra, erysipelas, pneumonia (lobar), syphilis, gonorrhea, chanchoid, lymphogranuloma, granuloma inguinale cancer.

The physician is requested to report to the health officer in writing within 24 hours all cases of communi cable diseases. All suspected cases must be reported and treated as positive until a clear diagnosis can be made. Neglect or refusal of a physician or householder to report cases of communicable disease, makes him liable to a penalty.

HEALTH EDUCATION

Good health is a joint responsibility of the individual and the community. It is acquired and maintained only by the observance of certain standards and regulations which have been determined by physicians, dentists and other professional persons through experimentation, research and investigation.

Information regarding the forming of correct health habits is disseminated through education and training. The state and local health departments have a responsibility along with physicians, dentists, scientists and other professional personnel in promulgating a program of health education.

The division of Health Education in the State Department of Health accepts the responsibility by conducting radio programs on health subjects over WNAD weekly throughout the year. Occasional programs giving information on health problems are given over other stations. The weekly programs over WNAD are recorded and are available to any radio station in Oklahoma. Requests for such recordings should be made to Dr. Mathews, the Commissioner.

The division also maintains a library of some 800 films and film strips covering the following fields: Cancer, Communicable Disease, Dental Health, First Aid, Food Handling, General Health, Maternal and Child Health, Mental Hygiene, Milk, Nursing, Nutrition, Sanitation, Tuberculosis, Venererial Disease and Water Supplies. These are available on loan to individuals and groups at no cost to the borrower. Most of these films are suitable for lay audiences. However, on the subject of Maternal and Child Health and on the subject of Mental Hygiene there are professional films suitable only for medical meetings, classes in medical school and other professional groups. These films are also available on loan.

A weekly newsletter is prepared and distributed to some 400 newspapers in the state. The division also prepares a monthly bulletin which has a circulation of 6500. A library of approximately 1500 volumes on different phases of health is maintained. There is also a periodical files of more than 100 professional and technical magazines. These are available on loan to health department personnel and other interested persons.

Arrangements may be made to furnish speakers and discussion leaders on subjects relating to the various phases of public health.

This division cooperates with other agencies in providing refresher courses for doctors and nurses, and in planning and conducting training courses for food handlers, and works with school administrators in programs designed to improve the health conditions for the school age child in Oklahoma.

Exhibits on health subjects for state and local meettings, for county and state fairs are prepared by the Health Education Division. These exhibits are available upon request to the Commissioner.

HOSPITAL LICENSURE AND CONSTRUCTION

The hospital licensure program has been in effect since July, 1946. Since that time there has been a gradual increase in compliance with the adopted standards for maintenance and operation. The basic principle of the licensing program is to encourage and promote better patient care in hospitals and related facilities. While the standards are of a minimum character, they are so designed as not to create a burden on any hospital and yet accomplish the desired results. That the program is sound in its purpose and beneficial in the results obtained thus far is evidenced through the general interest and cooperation of the hospitals.

In addition to a continuing licensure program conducted on a basis of assistance to the hospitals, the Federal Aid Hospital Construction Program (Hill-Burton) is also contributing to raising the standards of patient care by providing badly needed new facilities. Some of the projects completed are in areas previously without hospital facilities of any type; others are replacements to existing non-acceptable, hazardous hospitals and additions to inadequate facilities.

The construction program is presently authorized by Congress to continue until June 30, 1955. It is expected that by this time the need for additional hospital and related health facilities will have been fulfilled to a satisfactory level.

LABORATORIES

Laboratory service for the diagnosis and control of communicable disease is furnished through the Central Laboratory in Oklahoma City and five branch laboratories which are located in Elk City, Lawton, Miami, Muskogee, and Hugo.

Service is available for the diagnosis and control of the following diseases: diphtheria, tuberculosis, syphilis, gonorrhea, typhoid, dystentery (bacillary and amoebic), malaria, brucellosis, meningitis, pneumonia, tularemia, Vincent's infection, Rocky Mountain spotted fever, typhus, Q fever, rickettsialpox, rabies, and streptococcal infections. Specimens for tuberculosis and stool specimens for amebiosis are checked both micriscopically and by culture.

Darkfield examinations are made for syphilis. Spinal fluid is checked for total protein. The colloidal gold test is made. The quantitative VDRL test is also made on spinal fluids. Complement fixation tests are available for syphilis. Amebiosis (E histolytica), the rickettsial diseases, and certain viral diseases, including Eastern, Western and St. Louis encephalitis. The agglutianation test is done for leptospirosis. Quantitative serologic tests for syphilis (Kolmer, Kahn and VDRL) are done on blood specimens from serologic positive cases.

Streptococcus, shigella and salmonella typing service is available.

Rh testing is provided for patients attending health department prenatal clinics and for low-income cases.

Premarital and prenatal blood tests for syphilis are made, as required by law. Premarital certificates are issued. Oklahoma law requires the approval of all laboratories performing premarital and prenatal blood tests. This evaluation and approval of private, clinical and hospital laboratories is done by the Laboratory Division.

The Chemical Laboratory makes analyses of food, drugs, poisons, water, milk, alcohol and toxicological specimens. The state law requires the vitamin enrichment of flour and bread sold in the state. These samples are collected and the vitamin assay is made in the Chemistry Laboratory.

Examinations, both chemical and bacteriogical, are made on milk and water samples. Most of these come from municipal supplies, but many water samples from private supplies are also examined. Bacterial counts on glassware and utensils for food poisoning. Special tests are made to assist in the investigation of epidemics.

The following biological products are prepared and distributed to physicians without cost: typhoid vaccine, diphtheria toxoid, alum precipitated diphtheria toxoid, diphtheria and pertussis combined vaccine, pertussis vaccine, Schick test toxiu, old tuberculin and sterile distilled water.

Special containers for collecting mailing of specimens will be furnished upon request. Any information desired in regard to the collection of specimens, special tests, or the iuterpretation of reports will also be furnished upon request. Consultation in serology and bacteriology is offered by the staff of the Central Laboratory. Well-trained personnel is provided for this and the service is available to all interested laboratories without cost. The purpose of this service is to improve the general quality of the local laboratory services, to improve old techniques and to introduce new techniques and procedures.

Short refresher training is available for qualified laboratory workers from private, clinic and hospital laboratories. Training is offered in serology and bacteriology and is given in the Central Laboratory in Oklahoma City. Anyone interested should write to the Division of Laboratories, Oklahoma State Department of Health, Oklahoma City, for additional informatin.

LOCAL HEALTH SERVICES

Local health departments are made up of a team of public health workers: sanitarians, nurses and clerks, under the direction of a full-time public health physician. It is through these organizations that public health services are carried to the people of a given area.

The basic services of the local health departments are: vital statistics, communicable disease control, including venereal disease and tuberculosis; maternal and child health, including the health of the school age child; sanitation, including the supervision of food, water, and milk supplies, and the sanitary disposal of wastes; and health education. In some areas, programs for mental hygiene; cancer, diabetes, heart and other

chronic diseases, industrial health and accident prevention are in operation.

The Division of Local Health Service supervises the local health departments throughout the state. Health departments are in operation in the following counties and cities:

Health Department	Address
Adair County	Stilwell Community Hospital, Stilwell
Atoka County	Box 336, Atoka
Beaver County	Court House, Guymon*
Beckham County	111 South Broadway, Sayre
Blaine County	114 North Prouty, Watonga
Bryan County	418 West Evergreen, Durant
Caddo County	City Hall, Anadarko
Carter County	107 First Avenue, S.W., Ardmore
Cherokee County	302 South College, Tahlequah
Choctaw County	City Hall, Hugo
Cimarron County	Court House, Guymon*
Cleveland County	101 East Eufaula, Norman
Comanche County	10 East "B" Street, Lawton
Creek County	Humes Building, Sapulpa
Custer County	City Hall, Clinton
Delaware County	Jay
Garvin County	City Hall, Pauls Valley
Grady County	Borden Hospital, Chickasha
Hughes County	Medical Arts Building, Holdenville
Jefferson County	City Hall, Waurika
Kay County	1201 Hartford Avenue, Ponca City
Kingfisher County	Public Health Building, Kingfisher
Kiowa County	102½ East Fourth Street, Hobart
Latimer County	Court House, Wilburton
LeFlore County	Court House Annex, Poteau
Logan County	111½ West Oklahoma, Guthrie
McCurtain County	Court House, Idabel
McIntosh County	401 East Main, Madill
Mayes County	Pryor
Murray County	1023 West Broadway, Sulphur
Muskogee County	419 South Third, Muskogee
Okfuskee County	124½ West Broadway, Okemah
Oklahoma City	Municipal Building, Oklahoma City
Oklahoma County	206 Court House, Oklahoma City
Okmulgee County	918 North Seminole, Okmulgee
Ottawa County	204 Tidwell Building, Miami
Payne County	524 West Ninth, Stillwater
Pittsburg County	Third and Chadick Park, McAlester
Pontotoc County	106 East 13 Street, Ada
Pottawatomie County	218 North Philadelphia, Shawnee
Pushmataha County	Agriculture Building, Antlers
Rogers County	Court House, Claremore
Seminole County	110-120 West Fourth, Wewoka
Sequoyah County	Sallisaw
Stephens County	1021 Willow Street, Duncan
Texas County	Court House, Guymon
Tillman County	Library Building, Frederick
Tulsa County	521 North Boulder, Tulsa
Wagoner County	Library Building, Wagoner

*Administrative office for tri-county district.

MATERNAL AND CHILD HEALTH

The director of maternal and child health, the consultant nurse, and the nutritionists act as consultants to local health departments in helping them to develop their maternal and child health programs. The staff is also available for consultant services to hospitals in establishing standards for the care of mothers and infants.

A premature training center has been established at the Crippled Children's Hospital on a cooperative basis with the University of Oklahoma School of Medicine and Nursing. This center provides training for professional personnel for the hospital and for other hospitals throughout the state.

In cooperation with the University of Oklahoma Schools of Medicine and Nursing, this division arranges for postgraduate short courses in obstetrics and pediatrics for physicians and nurses throughout the state.

A series of prenatal letters has been prepared by this division and approved by the State Medical Association. These letters, along with other related material, are mailed out at monthly intervals to expectant mothers whose names have been furnished either by private physicians or by county health departments.

A wide variety of material and child health publications are available from the State Department of Health and local health departments to physicians who wish to use them in patient education. Maternity educational films are also available on a loan basis from the State Department of Health film library.

The school health program is planned jointly by an official committee appointed by the State Departments of Health and Education. Representatives from the State Medical and Dental Associations will serve as consultants to this committee.

MENTAL HYGIENE

This division carries on an educational program for the prevention of mental illness. The services of the professional staff, consisting of a part-time director who is a psychiatrist, a full-time psychiatric social worker and a full-time psychiatric nurse, are available to county health departments for regular discussion group meetings where selected cases from the community are presented. This staff is also available for lectures and as discussion leaders to professional and civic clubs, Parent-Teacher and school groups, health and welfare agencies, churches and interested lay groups.

This division contributes financial support to the University Mental Hygiene Clinic and the Tulsa Child Guidance Clinic; assists in promoting the program of the Oklahoma Association for Mental Health and the Community Mental Hygiene Clinic. It cooperates with the University of Oklahoma School of Medicine and the University Hospitals in conducting annual postgraduate short courses in Neuropsychiatry to which practicing physicians, nurses, social workers, school and clinical psychologists and other interested persons are invited.

Workshops are held acquainting the classroom teachers with the use of mental health principles in the schools. The division also works with teacher-training institutions to expand the training in mental health in the curriculum in the teacher-training institutions.

This program of mental health education is also promoted through the use of visual aids and the distribution of pamphlet material. The division has sponsored the production of four mental health films which are in the film library and with many other films on various phases of mental health are available for distribution to interested persons.

PREVENTIVE DENTISTRY

An educational and clinical program is conducted principally in organized local health areas. The division provides, upon request, consultation service to the dental and medical professions on common problems. Instances of this nature are:

1. The dental implications of venereal disease. Rapid dental surveys have become an established case-finding procedure for congenital syphilis in racial groups having a high prevalence of the disease.

2. Dental epidemiological problems. Vincent's infection in epidemic form is the usual occasion for consultation under this classification.

3. Dental caries control: (a) Lacto-bacillus acidolphilus salivary counts will be made to determine the degree of caries activity. Consultation on nutritional control of dental caries is available. (b) Consultation is available to municipalities, including local medical and dental societies, having fluorridation of their water supplies under consideration.

PUBLIC HEALTH NURSING

Since nursing service is an integral part of the total public health program, this division cooperates with all other divisions in planning and carrying the total program.

This division has the responsibility for staffing the budgetary positions in both the state and local health departments, and for the recruitment of additional nurses.

Public Health Nursing Consultant and Supervisory service is given to local health department personnel on all matters related to nursing. This same service is extended, upon request, to other official and non-official agencies. Hospital Consultaut nursing service is given to hospitals, nursing, rest and convalescent homes as a part of the hospital licensure program. Every effort is made to promote a continuity of nursing care, whether in the home or in the hospital.

An inservice training or staff education program is planned and implemented for the workers in the field. These meetings are designed to introduce programs of work or policies and to keep the personnel informed regarding the nurse's part in modern or changing methods of treatment of diseases.

SANITATION

A number of statutory functions are included under the heading of general sanitation, such as the sanitation of schools, public institutions, places of public resort, swimming pools, frozen food locker plants, approval of individual sewage disposal systems in areas designated by state statute, water shed sanitation, the providing of advisory service to state and local governments, and assistance to local health departments.

This program also makes available sanitation services in the epidemiological investigatiou and control of typhoid, salmonellosis, amebiasis, shigellosis, leptospirosis, food poisoning, and any of the diseases transmitted through the medium of contaminated food, milk, water, or by arthropods, which occur as a result of the sanitation of the environment.

Consultant service is also available to any city or town official in regard to sanitation ordinances or on problems related to rodent control and garbage and refuse disposal.

Milk Sanitation

The respousibility for the enforcement of the Oklahoma fluid market milk law has, through legislative action, beeu allocated to the State Department of Health. This section also extends advisory service to local health departments and to local milk control officials to attain proper labeling and does sanitation rating surveys to provide city officials with information relative to the effectiveuess of local enforcement. The services of this division are available to the State Epidemiologist and to local physicians in investigating probable sources of diseases transmitted through milk and milk products.

Occupational Health (Industrial Hygiene)

This section, through its engineering and laboratory services, investigates conditions in the environment of the working people with a view to eliminating exposures detrimental to their health. The physician can in many cases very materially help the effectiveness of this program by reporting cases of illness resulting from conditions of employment, thus enabling this section to investigate the situation and to give the necessary advice and council that will eliminate the cause.

Rodent-Arthropod Disease Vector Control

The State Department of Health, in cooperation with the Public Health Service Communicable Disease Center, sponsors this program which offers consultant service to individuals or communities in the prevention and control of arthropod and rodent vectors of human diseases. Vehicles and spray equipment are available for use in community fly and mosquito control programs, and for disaster aid.

Personnel are available to assist communities in determining the extent of rodent infestation and conducting of area poisoning programs for the control of commensal rats and mice, and aid in the development of programs for the control of disease-producing arthropods.

Rat-borne disease surveys are made, rodent blood specimens submitted to the State Health Department Laboratory for typhus complement-fixation tests, and rodent ectoparasite identifications are made.

Reported malaria cases are investigated to determine whether they are of local origin. Typhus cases are investigated and emergency control measures of rodents and ectoparasites are rendered where cases of rat-bite or rat-borne diseases are reported.

Information is also provided for the proper use of rodenticides and insecticides against rodents and arthropods of public health importance.

Water and Sewage

The purpose of the water and sewage section is to maintain the highest possible standards in the construction and operation of these community facilities through consultation and cooperation with officials in responsible charge of these community services. Contrary to popular thinking we still have a substantial number of communities today which, because of the disinterest of those locally responsible, are not providing the facilities or operation necessary to assure the protection of the public health.

TUBERCULOSIS CONTROL

Tuberculosis is declared dangerous and is on the list of reportable diseases. Two tuberculosis sanatoria, one at Talihina and one at Clinton, are maintained by the state. No charge is made for hospitalization. Application blanks for admission may be secured from the local health department or the county clerk's office. Applicants must have been residents of Oklahoma for one year.

Negro patients are hospitalized only at Western Oklahoma Tuberculosis Sanatorium, Clinton.

War veterans with tuberculosis are treated at the State Veterans Hospital, Sulphur. Admission information may be secured from the superintendent.

Indians are treated at two institutions operated by the Bureau of Indian Affairs. These hospitals are located at Talihina and at Shawnee and information regarding admission to either may be secured from the superintendent of the hospital or from the superintendent or of any of the Indian Jurisdictions in Oklahoma.

A tuberculosis case-finding program is carried out under this division. Regular chest x-ray clinics are held in counties with full-time health departments. Special clinics are held periodically in other areas of the state. In addition, a county-by-county mass x-ray survey program is being conducted.

VENEREAL DISEASE CONTROL

This division, as the title indicates, concerns itself with the control of venereal diseases. The State Department of Health will assist in completing a diagnosis and will provide treatment to the patient when requested to do so by a physician. This request is made upon a special form which is furnished by the State Department of Health. Persons suffering from a venereal disease in an infectious stage are subject to the laws of Oklahoma which deal with communicable diseases.

The Oklahoma State Department of Health provides three (3) strategically located diagnostic and treatment centers that operate exclusively on an out-patient basis. These centers are located at 1229 North Kelly, Oklahoma City; Phone, Regent 6-0171; 521 North Boulder, Tulsa, Phone 4-2138; and 10 East B Street, Lawton, Phone, 2735. These centers are equipped to do a complete venereal disease service, including epidemiology; and physicians are requested to contact the center nearest to them for consultant service and assistance in the epidemiology of the case.

Forms for confidential reporting of venereal disease

cases by physicians are furnished by the State Department of Health.

VITAL RECORDS AND STATISTICS

This division is responsible for filing and recording certificates of births, stillbirths and deaths which are sent from the district registrars. These records are on permanent file within a very few days following the birth or death.

Registering the birth of a person who is four or more years of age is accomplished by filing a delayed certificate of birth which requires that documentary proof be submitted to support the facts of birth claimed by the applicant.

Certified copies of birth, death and stillbirth certificates are issued upon the written and signed request of a qualified applicant for a fee of 50c each. Vital records by law are confidential in nature and only those having a "direct interest" in the matter recorded may receive certified copies. Only the State Registrar of Vital Statistics is authorized to issue certified copies.

The division also collects, compiles, tabulates and analyzes data derived from live birth, stillbirth and death certificates, reported cases of disease including malignant neoplasms, and venereal disease clinic activities. Statistical analysis of other public health data is made upon request from other divisions of the State Department of Health and by related organizations and agencies outside the Department.

Continuing publications of the public health statistics are: weekly report of communicable diseases, quarterly summaries of current birth and death statistics, and three annual publications entitled, PUBLIC HEALTH STATISTICS OF OKLAHOMA, Part I, Reportable Diseases; Part II, Births and Deaths; and Part III, Accidental Deaths.

THE OKLAHOMA COMMISSION FOR CRIPPLED CHILDREN

1141 North Robinson — Oklahoma City, Oklahoma

Telephone Regent 6-7551

Ira E. McConnell, Director

The 1949 Oklahoma Legislature rewrote the crippled children's law and, while rather radical changes were made in the mechanics of the act, the basic philosophy of hospital care for all needy children remains unaltered. All Oklahoma acts that have had to do with the treatment of crippled children have been unique, in that little if any distinction has been made in respect to the type of malady. A child with a hernia, or acute appendicitis has been, and is today, just as much a crippled child in the sight of the law as one with club feet, or one suffering from the after-effects of infantile paralysis.

The 1949 Crippled Children's Act brings the Oklahoma program in line with Federal requirements. It makes the Oklahoma Commission for Crippled Children the single responsible agency. The Commission is financed to a large extent by a direct state appropriation, rather than indirectly through the Oklahoma Hospital for Crippled Children as provided in the former law.

Section 13 of the 1949 Crippled Children's Act was declared unconstitutional in November of 1951 following which no provision for raising funds specifically earmarked for the medical care of crippled children has been available to the various counties in the State.

The cooperation of the State Department of Public Welfare is now specifically authorized. The Department retains full control of its respective funds. These funds are derived from an appropriation of three-fourths of one per cent of the sales tax which is made directly to the Department and is used largely for reimbursing the Oklahoma Commission for Crippled Children for expenditures made on behalf of children whose applications have been signed by county welfare directors or child welfare workers.

Patients may be accepted by the Oklahoma Commission for Crippled Children for treatment upon application by a county court, a county welfare worker, a health official, a licensed physician, or a parent. When the application is signed by an official of the State Welfare Department, the Commission may seek reimbursement from the State Assistance Fund (three-fourths of one per cent of the sales tax).

The 1949 Act provides for a Professional Advisory Committee to be appointed by the Commission. This Committee is to act as an advisory body to the Commission in the matters of hospital and medical care standards. Final decisions, however, are the prerogative of the Commission. The act, also, provides for the appointment of a director by the Commission who is the administrative and executive head of the program.

The Commission is composed of the following ex-officio members: Grady F. Mathews, M.D., State Commissioner of Health; Dean Mark Everett, Oklahoma University School of Medicine; Oliver Hodge, Ph.D., State Superintendent of Public Instruction, and L. E. Rader, Director, State Department of Public Welfare.

A Crippled child, under the provisions of the 1949 law, is one who has a remedial or treatable condition, and whose parents are financially unable to provide essential care. While the act itself does not limit treatment to hospital care, administrative and financial limitations make the program essentially one of treatment within a hospital.

Application forms are well distributed about the State. They can be obtained from any county judge's office, from most hospitals, and from the office of the county welfare director, or from a county health department. Also, forms are always available at the offices of the Oklahoma Commission for Crippled Children, 402 Baptist Building, Oklahoma City 3, Oklahoma, or 1516 South Quaker, Tulsa, Oklahoma.

STATE OF OKLAHOMA
DEPARTMENT OF MENTAL HEALTH

306 State Capitol Building Oklahoma City, Oklahoma

Telephone JAckson 8-2195

HAYDEN H. DONAHUE, M.D., Medical Director

MENTAL HEALTH BOARD MEMBERS

Harris G. Olmstead, Chairman
Grady F. Mathews, M.D.
Mark R. Everett, Ph.D.
Charles E. Leonard, M.D.
J. R. Colvert, M.D.

The Department of Mental Health was created during the Twenty-First Legislature by the passage of Senate Bill No. 122. This Act is known as the Mental Health Law. The Law was re-written during the Twenty-Second Legislature by passage of House Bill 437, making changes in some portions of the bill, especially in regard to some of the admission procedures. By the passage of the Act of the Twenty-First Legislature a new department in the State of Oklahoma was created and the governing board for the mental hospitals, epileptics and school for mental defectives was transferred from the State Board of Public Affairs to the Mental Health Board.

The Mental Health Board is composed of a Chairman, who is also Chairman of the Board of Affairs; the State Commissioner of Public Health; the Dean of the Medical School of the University of Oklahoma, or someone he may designate; a psychiatrist certified as a Diplomate of the American Board of Psychiatry and Neurology; and a Doctor of Medicine duly licensed to practice in the State of Oklahoma. The last two mentioned members are appointed by the Governor. The duties of the board pertain to the care and treatment and hospitalization of the mentally ill, mental defectives, and epileptic persons. The Mental Health Board is the administrative board of the Department of Mental Health and as such has sole and exclusive control of the several institutions of the department, and institutions that hereafter may be established when such institutions deal with the care and treatment of mentally ill, mentally defective, or epileptic persons. The State Board of Affairs continues as purchasing agent for the institutions in the Department of Mental Health.

The power to appoint a Medical Director for the Department of Mental Health is vested in the Mental Health Board. The Mental Health Law states that the Medical Director shall be a well-educated physician, graduated from a recognized Class-A medical school (as classified by the American Medical Association and the Association of American Medical Colleges), licensed to practice in the State of Oklahoma, certified as a Diplomate of the American Board of Psychiatry and Neurology and shall have at least ten years experience in the actual practice of psychiatry, at least five years of which shall have been in an institution for the care and treatment of persons suffering from mental illness, mental defectiveness, or epilepsy. The Mental Health Board appointed Charles F. Obermann, B.A., M.D., M.S., Medical Director of the Department of Mental Health in December of 1947 and he continues to serve in that capacity. He is a Diplomate of the American Board of Psychiatry and Neurology, Fellow of the American Psychiatric Association, and Fellow of the Southern Psychiatric Association. The Medical Director shall, in general, serve in the capacity of an advisor, an inspector, and as a coordinator. Specific duties are outlined in the Mental Health Law, among which he is to aid and assist, and cooperate with the State Department of Health, the University of Oklahoma, and other institutions of higher learning, public schools and others interested in public education in the problems of mental hygiene, and in the establishment of all-purpose mental hygiene clinics.

The following hospitals and school are within the Department of Mental Health: Western State Hospital, Fort Supply, Oklahoma, F. L. Adelman, M.D., Superintendent; Central State Hospital, Norman, Oklahoma, and Central State Hospital Annex, Lexington, Oklahoma, Charles A. Smith, M.D., Superintendent; Eastern State Hospital, Vinita, Oklahoma, F. M., Adams, M.D., Superintendent; Taft State Hospital, Taft, Oklahoma, (for Negro mentally ill, Mental defectives, epileptics), E. P. Henry, M.D., Superintendent; Pauls Valley State Hospital, Pauls Valley, Oklahoma, Carl T. Steen, M.D., Superintendent; Enid State School, Enid, Oklahoma, Anna T. Scruggs, F.A.A.M.D., Superintendent.

Procedure for Admission of Mentally Ill

Any person alleged to be mentally ill to a degree which warrants institutional care, and who is not in confinement on a criminal charge, and who has no criminal charges pending against him, may be admitted to and confined in a State hospital or a State psychopathic hospital or a licensed private institution by compliance with any one of the following admission procedures:

a. On voluntary application.
b. On certification by two (2) examiners, each of whom must qualify under Section 18a of the Act.
c. On court certification.

Qualified Examiners

Any physician, duly licensed to practice medicine by the Oklahoma Board of Medical Examiners shall be a qualified examiner under the terms of Section 18a of the Mental Health Law.

Procedure for discharge, convalescent leaves, visiting and return therefrom covered in the Mental Health Law.

Procedure for Admission and Release of Epileptic Persons

All procedures dealing with the admission to, or discharge or release from, or return to a State hospital from convalescent leave, visiting, or escape shall be identical for epileptic persons and for mentally ill persons, and all official papers dealing with such procedures shall be worded for epileptic persons the same as for mentally ill persons, except the word "epileptic" shall be used in place of the words "mentally ill."

Procedure for Mental Defectives

White mentally defective persons as described in this Section shall be admitted to the Enid State School, while colored (Negro) mentally defective persons of mental age described in this Section shall be admitted to the similar school on the grounds of the Taft State Hospital.

Admission of mental defectives is made by making written application on forms obtainable from the superintendents of the respective schools for mental defectives, and also from the Medical Director of the Department of Mental Health.

The program of the Department of Meutal Health can be summarized under four major fields of activity.

1. Patients safety, sanitation and comfort.
2. Patients intensive treatment, care and rehabilitation.
3. Prevention of mental disease. Each institution should develop into a mental health center with out-patient service.
4. Program for teaching, training and research. The teaching program should include teaching the public, as well as the medical, nursing, and allied professions, especially dietitians, occupational and recreational therapists, clinical psychologists, and psychiatric social workers.

At the time the Mental Health Department was established, one of the greatest problems was the lack of adequate facilities for patients. This is being corrected to some extent by the bond buildiug program which will be completed iu 1952. Another problem in carrying out this program to the full extent is the need for additional qualified and trained personnel, especially physicians, nurses and attendants and such auxiliary workers as psychiatric social workers, clinical psychologists, occupational therapists, dieticians, and other professional, technical and therapeutic personnel.

Approximately 10,000 individuals are hospitalized in the institutions in the Department of Mental Health. During the fiscal year, July 1, 1951 through June 30, 1952, 1,663 individuals were admitted for the first time to institutions in the department, and a total of 1,175 were returned to the institutions after a former admission. 297 individuals were re-admitted from other hospitals, most of which were located in other states. During the same period, 1,459 patients were released on convalescent leaves, 528 discharged directly from the hospitals, 700 patients died while in institutions, 286 left without permission and 72 were transferred making a total of 2,995 separating from the institutions. Also, during this period, 807 former patients were given a final discharge after a period of convalescent leave.

Increased appropriations available July 1, 1951 have made possible employment of additional personnel, and other improvements which have resulted in better care of patients in the institutions of the Board.

The Central State Hospital, Norman, Oklahoma, is affiliated with the Oklahoma University School of Medicine, assists in a teaching program for medical students and this hospital has a training school for student nurses affiliating in psychiatric nursing which opened September 1, 1949, with five nursing schools in the state affiliating.

A program for attendants on-the-job training has been instituted in a number of hospitals in the department, and this training program is being expanded as rapidly as possible. Plans to assist in training certain auxiliary personnel such as social workers and clinical psychologists are being accomplished.

It is the desire of the Department of Mental Health, through the Medical Director, Mental Health Board, and superintendents and staffs of the various hospitals in the department, to work with physicians in the state whose former patients require admission to an institution in the Department of Mental Health, so that these individuals can be given maximum care, cure, improvement and rehabilitation.

STATE VETERANS DEPARTMENT OF OKLAHOMA

State Historical Bldg., Rm. 2 P.O. Box 3067

Oklahoma City, Oklahoma

Telephone JAackson 5-3546

Don Davis, Director

John H. Sparkman, Deputy Director

STATE VETERANS HOSPITAL
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Will G. Craudall, M.D., Superintendent
Jack Meredith, Hospital Officer
Veterans Administratiou Hospital
Muskogee, Oklahoma
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OKLAHOMA VETERANS HOME
Ardmore, Oklahoma
Howard J. Lindell, Superintendent
Tim Turnbull, Hospital Officer
Veterans Administration Hospital
Oklahoma City, Oklahoma
Telephone MElrose 8-3377, Sta. 256

CLAIMS AND SERVICES

The State Veterans Department assists veterans in all problems with which they are confronted in the field of veterans affairs. The bulk of the work consists of assisting the veterans in filing applications for disability compensation, pension and death pension, as well as outpatient treatment and hospitalization. There is a staff maintained in the Veterans Administration Regional Offices at Muskogee and Oklahoma City whose primary responsibility it is to represent veterans and their dependents before the Rating Boards on matters concerning disability compensation, pensions and death benefits. They assist the veteran in that they help to evaluate evidence presented by the veteran on his claim as well as prepare his case for presentation. The field representatives of the State Veterans Department travel throughout the State on an itinerate basis, serving each county seat town and larger communities of the State once each week and the smaller communities once every ten days to two weeks. They work through the Service officers of the local posts of the American Legion and Veterans of Foreign Wars. These representatives are well qualified to assist veterans and their dependents in preparing claims for the Veterans Administration and securing hospitalization and out-patient treatment as well as assisting in any other phase of veterans' affairs. They are at the service of the people in their communities and will render any assistance to any person who is attempting to help a veteran. They may be reached generally through the service officers of the local veterans organization post. With their reputation and contacts, it is often possible for them to secure assistance for the veteran when other means have failed.

State Veterans Hospital

The State Veterans Hospital is located at Sulphur, Oklahoma, and is the direct responsibility of the War Veterans Commission. It is predominantly a tubercular hospital having 160 beds for tubercular patients and 55 beds for general medical and surgical cases. The surgery is limited to the less complicated cases. Veterans who have been honorably discharged and have been legal residents of the State of Oklahoma for at least one year are eligible for admission. Geuerally speaking it is best for the veteran's doctor to contact the hospital for admission; however, in emergency cases, anyone may call the Superintendent for admission. The Hospital is well staffed and is probably the best maintained State institution in Oklahoma.

The Oklahoma Veterans Home at Ardmore, Oklahoma was established by the 1949 Legislature. There were funds appropriated for the remodeling, repairing and equipping of the Institution for an approximate capacity of 120 veterans. Additional monies were allotted out of the recent bond issue and used to enlarge the institution to a total capacity of approximately 211. Veterans who have a chronic or convalescent disability of sufficient severity to prevent them from earning a living will be admitted if they have been honorably discharged and have been a legal resident of the State of Oklahoma for at least ten years, two of which must have been immediately preceding application to the home. All applicants will be examined physically at the State Veterans Hospital in Sulphur before admission to the Home. Inquiries should be directed to: Superintendent, Oklahoma Veterans Home, P. O. Box 985, Ardmore, Oklahoma.

UNIVERSITY HOSPITAL VETERANS WARD

A 32-bed ward is available to veterans who are legal residents of the State of Oklahoma, honorably discharged from wartime service and are financially unable to pay necessary expenses of hospitalization or medical treatment. Out-patient treatment is also available to veterans who meet the above requirements. Colored veterans are admitted under the above conditions when there is a vacancy in the general colored ward. Patients cannot be admitted with any form of communicable or venereal disease, tuberculosis, alcoholism or any condition which will not be benefited by treatment. Veterans are admitted upon the recommendation of the State Veterans Department, American Legion or Veterans of Foreign Wars Hospitalization Officers. In the event of an emergency case, anyone may call the hospitalization officer or the physician on duty at the Hospital.

VETERANS ADMINISTRATION

Oklahoma City Regional Office
1101 North Broadway, Oklahoma City, Okla.
Charles W. Robinson, M.D., Chief Medical Officer
V. A. Hospital — Will Rogers Field
Oklahoma City
Telephone ME 8-3377
Clarence E. Bates, M.D., Manager

Muskogee Regional Office
2nd & Court Streets, Muskogee, Okla.
Telephone 7020
George E. Riggs, M.D., Chief Medical Officer
V. A. Hospital — Memorial Station
Honor Heights Drive — Muskogee
Telephone 5430
Daniel H. Miller, M.D., Manager

Out-Patient Care Information

It is felt that an extract of necessary information concerning the obtaining of authorities for out-patient treatment and hospitalization members of the Oklahoma State Medical Association. Therefore, the pertinent rules, regulations and requirements are given in the following paragraphs, leaving out the nonessential portions, so that any physician desiring information on how to handle the veterans' medical problems will have a complete concise set of instructions which will assist hin in properly requesting treatment, completing his bills, and obtaining payment of same.

RULES AND REGULATIONS OF VETERANS ADMINISTRATION

SECTION I

Out-Patient Treatment

1. General considerations:

Normally an eligible veteran who lives in the immediate vicinity of a Veterans Administsation Clinic or Hospital will be referred to such for out-patient treatment. When a veteran lives at a distance from such a clinic or hospital, when facilities are not available there to properly care for him, when travel would be inadvisable because of the physical condition of the veteran, or whenever, in general, it is considered to be in the best interests of the veteran and the Governuent, treatment by a fee-basis doctor will be authorized. IT IS NOT THE RESPONSIBILITY OF THE VETERANS ADMINISTRATION TO PROVIDE MEDICAL CARE FOR A VETERAN'S FAMILY. UNDER NO CIRCUMSTANCES WILL THEY PAY FOR SUCH TREATMENT RENDERED BY A PRIVATE PHYSICIAN.

2. Eligibility for treatment by a private doctor:

a. It must be borne in mind that with very few exceptions the Veterans Administration is only allowed to pay a private doctor for treating a male or female veteran for a condition which a Veterans Administration rating board has ruled to be SERVICE-CONNECTED or which on medical grounds can be considered to be aggravating such a basic service-connected condition. FOR THIS REASON IT IS WISE TO SECURE AUTHORIZATION BEFORE STARTING TREATMENT.

b. OUT-PATIENT TREATMENT MAY NOT BE GIVEN FOR A NONSERVICE-CONNECTED DISABILITY TO EITHER MALE OR FEMALE VETERAN. YOU MUST REALIZE THAT THE VETERANS ADMINISTRATION HAS NO CHOICE IN THIS MATTER. IT IS THE LAW.

c. Most veterans whose cases have been adjudicated, CARRY PAPERS listing the disabilities that have been ruled service-connected in his case. In case of doubt, you can contact the Chief, Out Patient Section at Oklahoma City, or Dr. George E. Riggs at Mnskogee.

3. Authority to initiate out-patient treatment:

a. Authority for a private physician to render out-patient treatment to an eligible veteran is issued by the Chief, Out-Patient Section, of a regional office. This authority is issued in response to a request from the veteran or from his doctor, or it may be initiated by the Chief, Out-Patient Section. If the veteran requests treatment, he should nse a special form. The doctor's request may be made by telephone, telegraph, or by letter. Whenever possible, at least verbal authorization should be obtained before initiating treatment. If this proves impracticable, yon must MAKE YOUR REQUEST IN ONE WAY OR ANOTHER WITHIN TEN DAYS.

b. Under all normal circumstances treatment can be authorized only to include the calendar month. Along with the authorization you will receive copies of VA Form 2690b. Form 2690b should be used to request authority to continue treatment. Fill out only that part of the form that is necessary to show facts.

4. Reports of treatment and authority to continue treatment:

a. Form 2690b, as its title indicates, is a monthly or final report of treatment rendered. FORM 2690b MUST ALWAYS BE SUBMITTED AT THE CONCLUSION OF A CASE.

b. If you feel that the patient will require treatment during the succeeding month, Form 2690b, will be used to request such authority and to submit a monthly report of treatment. Use the back of the form if more space is needed. IT SHOULD BE SUBMITTED BY THE 23RD OF THE MONTH SO THE CHIEF, OUT-

PATIENT SECTION WILL HAVE TIME TO GET THE NEW AUTHORITY TO YOU BEFORE THE FIRST OF THE MONTH.

(1) The doctor's fee cannot exceed the fee shown on the face of the authority. If the authority does not cover the amount of treatment rendered—return and request a new authority. Item numbers ou the doctor's bill must be the same as on the authority.

(2) The original of the authority as well as the original of the doctor's bill must be returned to the Veterans Administration office.

(3) A narrative report in duplicate is required on any type of examiuation before payment can be made.

(4) Give the veteran's name, C-number and address on all correspondence.

(5) Give your diagnosis on all requests.

SECTION II

Hospitalization

1. General considerations:

Requests for hospitalization or domiciliary care should be executed by a veteran or his representative on VA Form 10-P-10. Veterans usually secure these forms from the Veterans Administration Contact Offiicers or from service organizations such as the Red Cross, Americau Legion, etc. The examining doctor should fill out the medical certificate and mail the completed form to the nearest Veterans Administration Regioual Office. (Veterans Administration contact officers are allowed to authorize such examination. When one of these officers has authorized this service, send your bill to the nearest Veterans Administration regional office) All the Veterans Administration regulations predicate that a Veterans Administration hospital will be the first choice for hospitalization and treatment of a veteran.

2. Emergency hospitalization:

a. A veteran may be hospitalized and treated in a private hospital for a service-connected disability if there is uo bed available for him in a Veterans Administration hospital, or if the distance from a Veterans Administration hospital, or the condition of the patient render it hazardous to life or health to transport him to such a hospital. Authority for such hospitalization aud treatment should be secured in advance from the Chief, Hospitalization, of the nearest regional office. Collect telephone calls or telegrams may be used. IF THIS PROVES IMPRACTICABLE, AUTHORITY MUST BE REQUESTED WITHIN 48 HOURS. Form 10-P-10 should be executed and forwarded later so that the record may be complete.

IN ADDITION TO EMERGENCY SERVICE-CONNECTED CONDITIONS, A PUBLIC LAW 16 TRAINEE IS ELIGIBLE FOR HOSPITALIZATION FOR EMERGENCY SURGERY FOR ANY CONDITION INTERFERING WITH HIS TRAINING. Authority for such hospitalization and treatment should be secured in advance from the Chief of Professional Section, who is Dr. Alvin W. Paulson in the Oklahoma City office, and Dr. George E. Riggs in the Muskogee office.

b. THE VETERANS ADMINISTRATION CANNOT PAY FOR THE PRIVATE HOSPITALIZATION AND TREATMENT OF MALE VETERANS SUFFERING FROM DISABILITIES WHICH ARE NOT SERVICE-CONNECTED.

(1) Private hospitalization and treatment may be authorized for a female veteran for the treatment of a nonservice-connected disability (except normal pregnancy). You should make every effort to secure prior authorization in such cases. If this is impossible, make your request within forty-eight hours, as above.

SECTION III

Prescriptions

1. When it is necessary for you to prescribe medication or medical requisites for a veteran whom you are authorized to treat as an out patient, there are two methods you may follow. Prescriptions may be written on your own or Veterans Administration prescription blanks. a Prescriptions for medication and** medical requisites may be filled by any private pharmacy which is a member of the State Pharmaceutical Association. All of these Associations have contracts with the Veterans Administration. You must execute and sign the following certificate on the front or back of the prescription: "I am authorized to treat and prescribe for the above-uamed Admiuistration patient."

2. A member of the Sate Pharmaceutical Association is known as "participating pharmacist." He will care for all the rest of the details. Except in emergencies only, the participating pharmacist can fill the prescription and secure reimbursement from the Veteraus Administration. In case there are no participating pharmacists in your community, please uotify the Chief, Out-Patient Section, who will contact the Secretary of the State Pharmaceutical Association and attempt to get the pharmacist enlisted for participatiou iu your town.

Before a prescription can be issued in any month, an authority must have been issued you for at least one office visit for that month. When such is doue, then all prescriptions issued in treatment of the service-connected disability in that month will be valid.

**At the present time, only the following "medical requisites" may be supplied by private phamacists: Insuline syringes and needles, atomizers, nebulizers, hot water bottles, fountain syringes, ice bags, urinals, bedpans, or enema caus, feeding tubes, aud ear and ulcer syringes.

SECTION IV

Bills

1. A form for your bill is printed on your authorization to perform the services. You will receive four copies of this authorization, a signed original and three carbon copies.

2. All bills should be itemized in triplicate using the original and two copies. Your name at the top of the bill should be exactly the same as it appears on the face of the authorization. Sign the certificate below the bill in the same way, on the original ouly.

3. Send the original of the bill bearing your signature, and two copies of the bill to the office which authorized your services. The fourth copy of the authorizatin may be retained for your records.

PLEASE

NOTIFY THE EXECUTIVE OFFICE

OF ANY CHANGE IN YOUR ADDRESS

VOCATIONAL REHABILITATION DIVISION

STATE BOARD OF VOCATIONAL EDUCATION

1141 North Robinson Oklahoma City, Okla.

Telephone RE 6-7551

VOYLE C. SCURLOCK, Director

The Vocational Rehabilitation Division of the State Board of Education has functioned in Oklahoma since 1925. Its activity can be defined as an extension of the public school system to a selected group of disabled persons. Its purpose is to give such services as are necessary to enable the impaired individuals to enter, or re-enter, employment in industry where they can make the best use of their skills and abilities.

Eligibility

The minimum age limit is sixteen years; there is no maximum age limit, but the applicant must not be too old to be reasonably expected to resume employment of some type. Each applicant must have a permanent defect, but must be physically able and mentally capable of carrying on successfully in employment on a competitive basis. He must have such potentialities that he can be expected to develop a marketable skill as a result of the service provided for him.

Functions

The services of Vocational Rehabilitation are in the following areas:

1. Vocational Guidance

The client is given information and advice as to vocational opportunities as well as the physical, mental, educational, temperamental and social requirements of various occupational fields.

Individual counseling and advice is given in the selection of a suitable job objective. The counseling is based on a study of the indiidual's physical, mental, social and economic assets and liabilities as well as on available training and employment opportunities.

2. Physical Restoration

Medical, surgical, psychiatric, and dental care may be given to remove or reduce a disability that creates an occupational handicap. These services are provided only when the client is financially unable to provide them for himself.

Prostheses may be furnished, on a basis of need, if the client's ability to function on the job can be improved thereby.

3. Vocational Training

Arrangements may be made for any type of training that is vocational in nature and will lead toward a definite line of work. It may be given in a state institution, a private trade or commercial school, through a private tutor or in a commercial or industrial establishment. The cost of tuition, books, tools and instructional supplies may be provided. Maintenance on a basis of need may be given during the training period. Counseling and supervision are provided during the training period to assure that the training is sufficiently thorough and of such nature as to be effective.

4. Selective Placement

Selective placement is that service which assists the client in finding the occupation best suited to his physical and mental capabilities. Jobs are analyzed to determine which ones may be held by individuals with various handicaps. The individual client is studied to determine the position for which he is best suited.

Counsel and advice are given in regard to making applications for jobs, contacting employers, adjusting to work routines, cooperating with co-workers, and whatever seems indicated to help the client adapt himself to industry. Follow-up is maintained for a reasonable length of time after employment is secured to be certain that the client has made the necessary adjustments and for the purpose of determining that his rehabilitation is complete.

Physical Restoration Program

Prior to 1943, the Vocational Rehabilitation Service had no funds for medical care. The vocational training program was planned around the client's disability, since there was no other provision for the care of the indigent person with a disability, particularly those needing remedial or elective treatment.

Recent Federal legislation (1943) has made funds available to states and territories on a dollar per dollar matching basis to provide treatment for the permanently disable person who cannot provide such treatment for himself. It is not a general medical program and does not include the care of the acutely ill. Indigent clients whose occupational handicap can be removed or reduced by treatment are eligible for this service.

1. Program Direction

A medical consultant, functioning on a part time basis, heads up this service. He advises in regard to the execution of policies for physical restoration, assisting the agency in its contacts with the medical and associated professions and in the maintenance of standards established for the selection of physicians, hospitals, and other professional personnel and facilities necessary to the proper functioning of the program.

The medical care program is directly supevised by a medical social worker with a master's degree in her profession. She has a number of years experience in hospital and public medical care programs. She works under the direction of the medical consultant.

2. Medical Advisory Committee

Realizing the impossibility of working out such a plan without the advice and close cooperation of the medical profession, the State Board of Education asked the Oklahoma State Medical Association, the Oklahoma State Dental Society, and the Oklahoma Sate Hospital Association to suggest members for an advisory committee to work with the Director, the medical consultant, and the supervisor of physical restoration.

Its duties are those of advising on the policies and procedures of a statewide medical care plan. The problem of setting up standards for physicians and surgeons participating in the program, fees to be paid for their services, standards for hospitalization and fees to be paid hospitals, standards for related personnel and items needed to carry out a medical treatment plan and fees to be paid for such services have been established by the advisory committee. The committee does not deal with individual cases but the over-all policies guiding the program.

3. Types of Cases Accepted

Any condition, regardless of its physical or mental origin, that is an impediment to the individual's occupational performance, is relatively stable, and is amenable to treatment so that it can be remedied to a substantial degree in a reasonable length of time is acceptable. The provisions eliminate the acutely ill and the long-time chronic cases who do not respond to treatment and who are, therefore, not in need of vocational assistance. Surgery of cosmetic value may be done if the condition mitigates against the client's securing the type of work for which he is fitted or if it creates an emotional handicap.

Dental care is provided for an individual whose vo-

cational handicap is caused by, or seriously aggravated by, a deutal problem. This service does not take eare of minor dental needs but of major conditions which constitute or create a vocational disability. It is provided only to those who are unable to pay for the service themselves. Fees paid to dentists are those approved by the Oklahoma State Dental Society.

Psychiatrie care is provided for those who can be rehabilitated by it. In the past, only physical disabilities were considered in this program. Now, however, individuals who are vocationally handicapped because of mental illness are accepted for service. This is necessarily a highly selected group because of the lack of adequate facilities for psychiatrie care in the state as well as the lack of experience in handling such individuals on the part of the agency's staff. Following complete physical and psychiatric examinations, an individual may be accepted for vocational rehabilitation services if, in the opinion of the psychiatrist, a properly selected job or suitable training would rehabilitate the individual.

The individual with the obvious disability—the loss of a limb, blindness, deafness, or paralysis—was formerly the only client referred to this service. Other permanently disabled persons, however, may be in need of rehabilitation. The types accepted by the agency included the epileptie, the diabetic, the arrested tuberculosis case, and the cardiae eripple.

Since August, 1951, the severely disabled person in Oklahoma has been given a new opportunity for help. At that time, a Department of Physical Medicine and Rehabilitation was opened at the Oklahoma A. & M. School of Technical Training, Okmulgee, Oklahoma.

The Department is called "Rehabiltation Center" and occupies a number of wings of the old Glennan General Hospital. Dr. John W. Deyton, Psyehiatrist, is in charge of the work being done. While this is not a service directly furnished by the Vocational Rehabilitation Agency, most of the patients admitted during the first year were clients of that agency. Inquiries regarding the rehabilitation of paraplegies, amputees, post-polios, etc., should be directed to Dr. Peyton.

STATE OF OKLAHOMA

DEPARTMENT OF PUBLIC WELFARE

Capitol Office Building — Oklahoma City, Oklahoma

Telephone JA 8-7561

C. P. BONDURANT, M.D., Chairman
Oklahoma Public Welfare Commission

L. E. RADER,
Director of Public Welfare

The Oklahoma Social Security Amendment, adopted July 1936, provides for the relief and care of needy aged persons, and of other needy persons who, because of immature age, physical infirmity, disability, or other eauses are unable to provide for themselves. The Department is under the control of the Oklahoma Public Welfare Commission, a nine-member body appointed by the Governor. This group is responsible for the selection of the Director.

The Department is financed from the State Assistance Fund, derived from the two per cent sales tax, supplemented by Federal funds from the Social Seurity Administration on a basis which provides more than fifty per cent of all funds expended.

The relief and services which the Department is charged by law for providing to the needy persons of the State are given through a number of programs which are separate for administrative and auditing purposes but which are closely related in the interest of providing a well-rounded service to the needy individual or family.

Public assistance is provided to four groups of persons in Oklahoma. These groups, commonly referred to as categories, include the aged, the blind, the disabled, and dependent children. Three of these groups have been aided since the inception of the program in 1936. The fourth group has been aided since July 1, 1951, at which time Federal legislation was enacted which provided Federal matching for disabled persons, in addition to the other three groups. In all categories, economic need is a factor of eligibility. The Department determines the amount of payment to recipients on the basis of a budget which measures each client's basic requirements for food, clothing, shelter, utilities, personal and household maintenance items and a $3.00 allowance for medicine. The client's resources are then supplemented from the Department's assistance fuuds as necessary to meet these requirements.

Through the old-age assistance program, the Department was assisting as of June 30, 1952, 94,260 individuals. The expenditure for June 1952 was $5,386,-569.00 and the average payment was $57.15. In addition to being in need, individuals must be sixty-five years of age or older and must be a resident of Oklahoma in order to qualify for old-age assistance. Seventy-five per cent of the total state assistance fund is earmarked by law for the aged. It has been possible to help members of the group according to their full monthly budget need and since April 1952, the amount of the payment has not been subject to any maximum.

Through the program of Aid to the Blind, needy residents with visual acuity of 20/200 or less are similarly assisted. As of June 1952, 2,472 recipients received a total of $154,715, with an average payment of $62.59 per person. Funds have also permitted rendering assistance to this group according to their full need as determined by the Department's budget, and without limit to any specific maximum. Amendment to the State Social Security Act, effective July 1, 1951, increased the portion of the State Assistance fund earmarked for Aid to Blind from two to two and one-half per cent.

Aid to Dependent Children is extended to children in their own home who are deprived of care or support because a parent is dead, ill or absent from the home. It is the objective of this program that no child shall be deprived of a home with his own family by reason of poverty alone, due to the loss of wage earner in the family. In June 1952, 48,078 children in 18,898 families received a total of $1,340,792.00, or an average payment of $70.95 to each family and an average of $20.06 to each person in the aid to dependent children case.

The 1951 amendment reduced from seventeen per cent to fifteen and one-fourth per cent the portion of the State Assistance fund earmarked for the aid to dependent children program. This fund was not sufficient to meet the full needs as established by the Department's budget for children in families eligible for this type of assistance and it has been necessary to limit the income which the family has from its own sources and from the assistance payment to eighty per cent of the total requirements.

Aid to the Permanently and Totally Disabled was granted to 2,644 persons during June 1952. Three per

cent of the total State Assistance Fund is allocated to this category. In June 1952, a total of $152,308 was expended through this program with average payments being $57.61. Since May 1952, funds have been sufficient to meet full needs according to the Department's budget. The payment is not subject to a maximum.

A permanent disability is defined as a condition for which there is no known therapy which gives reasonable expectation of curing or controlling the disability within the foreseeable future or one which is static as long as therapy is not available to the patient. The patient is considered totally disabled if the permanent disability results in impaired function to the extent that gainful or useful work is precluded.

Funds available to the Department have never permitted the inclusion of medical and hospital services along with food, shelter, etc. as items of a basic standard budget. It has been possible to provide nursing or attendant care to those in need of this service and it has also been possible to provide each person with an allowance for medicine and drugs in the amount of $3.00. Medicine beyond that amount can be provided only for persons with a chronic condition which causes sevére pain or which is life-endangering. Information regarding the patient's condition and the prescribed medication is reviewed by the Department's Medical Consultation Service, which consists of a Physician and a Medical Social Worker, who act as a Review Team. Funds available have not been sufficient to permit payment to the local doctor who provides the Review Team with the needed information regarding the patient's diagnosis and his needed medication. So long as the Department funds are sufficient to provide only the so-called "basic necessities" for all cases, the Commission deems it inadvisable to reduce the standards for those necessities in order to provide any medical or hospital service beyond what is prescribed above.

Since illness is an important factor in causing economic dependency it is a continuing objective of the Department to mobilize health resources for the treatment of illness and to aid each client in planning to avail himself of the opportunity to make use of such resources. The medical needs of many persons in all categories are met through other State facilities and programs, such as Crippled Children, University Hospital, State-owned hospitals, Vocational Rehabilitation and the Public Health Department. Facilities for special groups such as Veterans and Indians, also serve many assistance recipients. County indigent funds of the County Commissioners are used to pay for needed medical services for many assistance recipients throughout the State.

The inauguration of the assistance program for Aid to the Permanently and Totally Disabled in July 1951, gave added evidence of the importance of health problems in causing economic dependency. All individuals aided through this program are, by definition, handicapped or ill. It has been the Department's policy in this program, as in the other groups to evaluate every possibility of rehabilitation and of improvement through medical service and to aid each individual client in locating and making use of any available facilities through which the needed service might be secured.

Child Welfare provides specialized services in the field of child care, including preventive and protective services. This service is made available through the district offices of the Division. In addition to this service, state services are made available to encourage community child welfare programs. Child Welfare is also responsible for the supervision of the Crippled Children's Assistance program under the State Assistance Fund.

Child Welfare gives services to children in their own homes. For the child who needs care away from his own home, Child Welfare arranges for placement of the child in a foster home or in an institution, depending upon the needs of the individual child. For those children committed to Child Welfare by the County Courts for the purpose of finding an adoptive home, a study is made of the child in order to select adoptive parents who can meet the child's needs.

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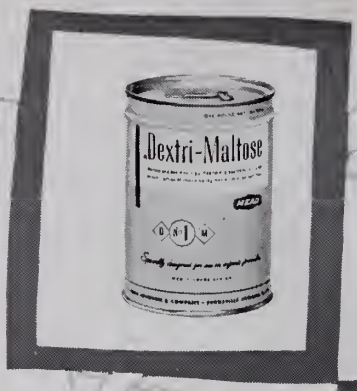


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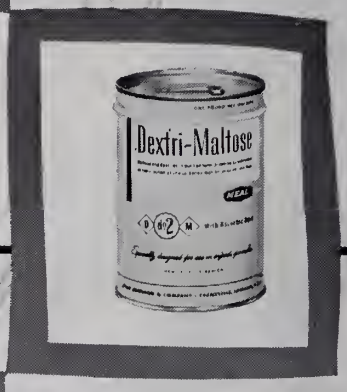


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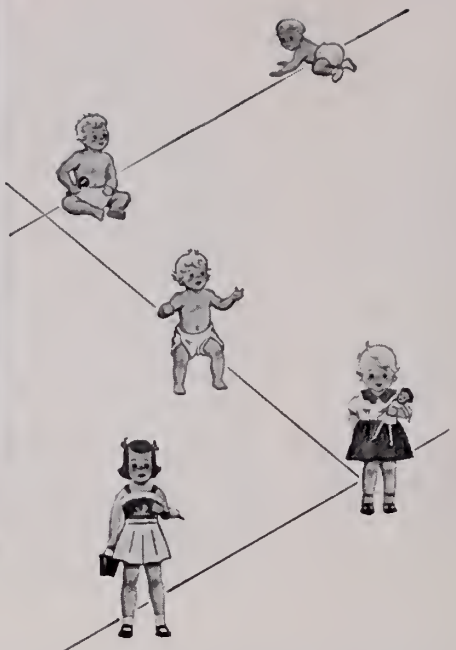
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